



***SUBSTANCE USE DISORDER
TREATMENT SERVICES
PROVIDER MANUAL***

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**Los Angeles County
Department of Public Health**
Substance Abuse Prevention and Control

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NOTE: Given the continual evolution of the field of addiction treatment, the Provider Manual is a living document and will evolve with the availability of new information and research, or changes in policy, regulatory mandates, or contractual agreements. As a result, this document is subject to ongoing review and revision at the discretion of SAPC.



SECTION 1.

MODERNIZING SUBSTANCE USE DISORDER TREATMENT

Transforming the Treatment System of Care

The System Transformation to Advance Recovery and Treatment, Los Angeles County's substance use disorder Organized Delivery System (START-ODS) provides increased access to substance use disorder (SUD) treatment services for youth and adults who are enrolled or eligible for Medi-Cal, My Health LA and/or participating in another County funded program. It also presents an opportunity for the County to achieve the following:

- Integrating physical and mental health service needs with SUD services;
- Raising quality standards to improve health outcomes;
- Providing the right services, at the right time, in the right setting, for the right duration;
- Establishing a single benefit package for publicly funded SUD services regardless of referral source or insurance plan; and
- Solidifying SUD's status as a chronic health condition rather than as an acute condition.

These enhancements will enable SUD patients to receive quality services that match their individualized needs and preferences, and overall improve health and social outcomes.

This document, along with other federal, state and local regulations* govern delivery of SUD treatment services in Los Angeles County. The Provider Manual is specifically designed to be used by all administrative and direct service staff to ensure understanding of core values for the SUD system of care. It also provides clinical and business expectations meant to ensure delivery of quality and outcome-based services.

**42 Code of Federal Regulations (C.F.R.) Part 2 Confidentiality of Substance Use Disorder Patient Records; 42 C.F.R. Part 438; Health Insurance Portability and Accountability Act (HIPAA); California Code of Regulations (CCR) Title 9 Chapter 8 Certification of Alcohol and other Drug counselors; CCR Title 22, Section 51341.1 Drug Medi-Cal Substance Use Disorder; Drug Medi-Cal Organized Delivery System Special Terms and Conditions; Department of Health Care Services Perinatal Practice Guidelines and Youth Treatment Guidelines; START-ODS Implementation Plan and Finance and Rates Plan; and the Contract including but not limited to the Specific Services to be Provided and Bulletins.*

Substance Use Disorders as a Chronic Disease

Substance use disorders (SUDs) are often chronic, relapsing conditions of the brain that cause compulsive drug seeking and use, despite harmful consequences to individuals and their social network (National Institute on Drug Abuse).

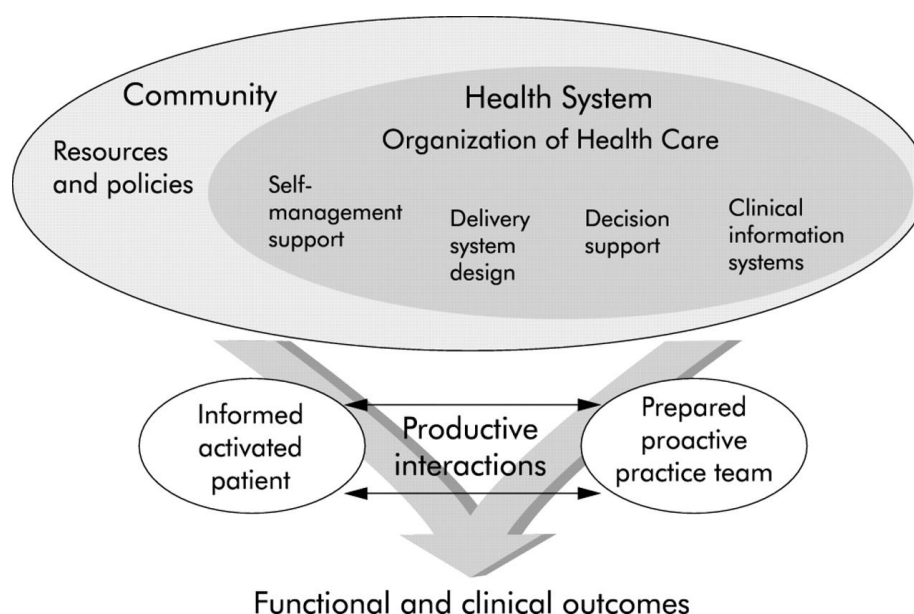
A chronic disease is one that cannot be easily or simply cured, but instead must be treated, managed, and monitored over time. For example, while an ear infection is considered an acute or episodic condition that requires a fixed period of treatment to obtain a cure, SUDs generally requires treatment and management over a much longer period, and at times over the course of a lifetime. Examples of other chronic health conditions are heart disease, diabetes and asthma. While some individuals may develop a SUD and achieve recovery after minimal intervention over a brief period of time, most individuals will exhibit a more chronic and relapsing course.

The chronicity of SUDs frames the approach necessary to effectively treat these conditions. Chronic conditions need to be managed via a chronic model of care that offers a continuum of services tailored to an individual's needs at that point in time. As an individual advance along their recovery journey, the type and intensity of treatment services they receive should change

and reflect the severity and nature of the patient's SUD. This approach highlights the importance of care coordination and access to a full continuum of care that offers varying levels of care best tailored to meet patient needs. As a result, a key goal of SUD treatment is to provide the right service, at the right time, for the right duration, in the right setting.

Wagner's "Chronic Care Model" (CCM; see **Figure 1**) identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. The components of the CCM are described in greater detail in **Table 1**.

Figure 1. Chronic Care Model (CCM)



Source: The MacColl Institute, © ACP-ASIM Journals and Books

Table 1.

Component of the Chronic Care Model

1. **Health Systems:** Create a culture, organization and mechanisms that promote safe, high quality care.
 - Visibly support improvement at all levels of the organization, beginning with the senior leader
 - Promote effective improvement strategies aimed at comprehensive system change
 - Encourage open and systematic handling of errors and quality problems to improve care (2003 update)
 - Provide incentives based on quality of care
 - Develop agreements that facilitate care coordination within and across organizations (2003 update)
2. **Delivery System Design:** Assure the delivery of effective, efficient clinical care and self-management support
 - Define roles and distribute tasks among team members
 - Use planned interactions to support evidence-based care
 - Provide clinical case management services for complex patients
 - Ensure regular follow-up by the care team
 - Give care that patients understand and that fits with their cultural background
3. **Decision Support:** Promote clinical care that is consistent with scientific evidence and patient preferences
 - Embed evidence-based guidelines into daily clinical practice
 - Share evidence-based guidelines and information with patients to encourage their participation
 - Use proven provider education methods
 - Integrate specialist expertise and primary care
4. **Clinical Information Systems:** Organize patient and population data to facilitate efficient and effective care
 - Provide timely reminders for providers and patients
 - Identify relevant subpopulations for proactive care
 - Facilitate individual patient care planning
 - Share information with patients and providers to coordinate care
 - Monitor performance of practice team and care system
5. **Self-Management Support:** Empower and prepare patients to manage their health and health care
 - Emphasize the patient's central role in managing their health
 - Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
 - Organize internal and community resources to provide ongoing self-management support to patients
6. **The Community:** Mobilize community resources to meet needs of patients
 - Encourage patients to participate in effective community programs
 - Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
 - Advocate for policies to improve patient care

Source: http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18

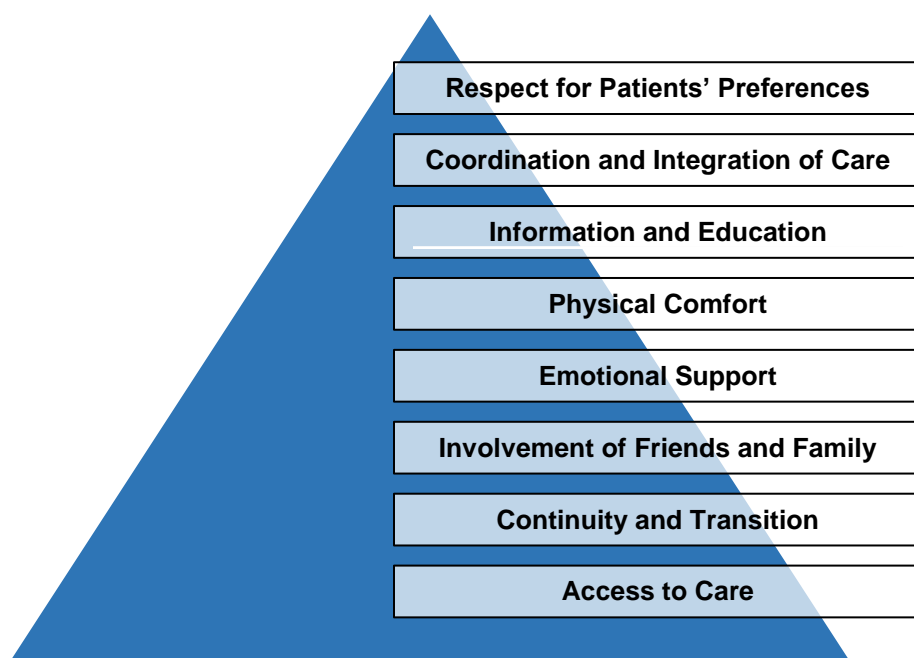
Effective care of chronic conditions, such as SUD, is characterized by productive interactions between engaged patients, as well as their family and caregivers, and a skilled team of service providers, including counselors and other health professionals.

Defining Patient-Centered Care

Treatment retention is one of the most important keys to the success of SUD care, given that an individual cannot benefit from treatment if they do not participate in it. Furthermore, one of the critical ingredients of engaging and retaining SUD patients in treatment is the ability to deliver patient-centered care.

Patient-centered care is a collaborative approach to SUD service delivery that emphasizes respect for the patient and care that is responsive to an individual's preferences, needs, well-being, and values. Patient-centered care does not mean always doing exactly what the patient desires. There will be instances when clinical judgment is in the best interest of the patient yet does not align with patient desire. However, providers should consider patient preferences and values, and let them guide the decision-making process.

Figure 2. Picker Principles of Patient-Centered Care



Source: <http://pickerinstitute.org/about/picker-principles/>

Instead of the needs or policies of the clinic/facility guiding service delivery needs, patient-centered care requires flexibility by both the providers delivering the services and the program within which the services are being delivered. In doing so, SUD programs will be better able to engage their patients and better positioned to deliver high-quality care by cultivating an environment in which patients' individualized needs are prioritized in all aspects of care delivery.

Ensuring a Standard Quality of Service

The specialty SUD system is a core component of the larger healthcare system. As such, it needs to maintain minimum standards and expectations to ensure high quality services for the patient population being served. Similar to the management of other chronic conditions, these

Making the Connection

Standards ensure consistent and quality care across provider organization but allow for enough flexibility to meet the specific needs of the target population.

minimum standards for SUDs ensure a reasonable degree of consistency across service providers, while also allowing for sufficient flexibility to provide services that are tailored to the individualized needs of patients. For example, an individual with diabetes may receive slightly different services depending on the provider (e.g., recommendations about dietary/lifestyle changes), but the treatment and management approach should be guided by certain best practice and clinical standards.

Similarly, SUD services need to be guided by best practice and clinical standards, which include the use of evidence-based practices such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) techniques.

It is important to note that standards-based care and individualized care are not mutually exclusive. Service providers can offer individualized and patient-centered care that also meets certain minimum best practice and clinical standards.

This Provider Manual describes a framework of standards that involve patient services, clinical and business processes, and pertains to all providers within the SAPC network of care. In outlining these minimum expectations, this Provider Manual establishes an infrastructure of quality for the specialty SUD treatment system throughout Los Angeles County.

Integration and Coordination of Care

To better serve the comprehensive needs of its patient population, a key goal of the specialty SUD system is to better integrate SUD care into healthcare and social service systems, and vice versa. In addition, there is also need for the specialty SUD system to be better organized and coordinated so that patients are effectively accessing the full continuum of SUD services and levels of care available to them.

Integrated care is the routine and systematic coordination of health services so that the varied needs of patients are addressed both comprehensively and cohesively. An example of care integration is an SUD program that has primary care and mental health providers stationed in the SUD program so that patients with multiple healthcare needs can have them addressed in one location. Integrating social services such as housing assistance is also important. Broadly speaking, integrated care should make it easier for patients to receive the care they need by positioning health services in ways that make them more accessible.

Care coordination is the deliberate organization of patient care activities and sharing of information among care providers to ensure that the needs of patients are addressed comprehensively and across all their areas of need. Care coordination needs to be patient-centered and driven by a combination of patient need and preference. It should also be based on clinical judgment, so that the information being shared, and the care being coordinated is in the best interests of the patient. The primary goal of care coordination is to ensure that while there may be multiple health and social service providers involved in an individual's care, the

services being provided are all organized and coordinated to collectively provide comprehensive, appropriate, and effective care to the patient.

Examples of specific care coordination activities are highlighted in **Table 2**.

Table 2.

Examples of Specific Care Coordination Activities
Assessing patient needs and goals
Creating a proactive care plan
Monitoring and follow up, including responding to changes in patients' needs
Helping with transitions of care
Supporting patients' self-management goals
Linking to community resources
Working to align resources with patient and population needs
Communicating/sharing knowledge
Establishing accountability and agreeing on responsibility

In summary, both integrated and coordinated care can improve outcomes for patients and providers alike.



SECTION 2.

PATIENT SERVICE STANDARDS

The Substance Use Disorder Benefit Package

The SUD benefit package consists of the scope of services and levels of care that are available to individuals in Los Angeles County who are eligible for services in the specialty SUD system. Given that the recovery needs for each individual with a SUD are unique, a comprehensive continuum of care is necessary to meet the needs of all beneficiaries within the specialty SUD system.

The SUD benefit package includes a range of outpatient, residential, withdrawal management, opioid treatment programs, recovery bridge housing, and recovery support services (that are outlined in more detail herein). Individuals should transition between levels of care as medically necessary.

Eligibility Determination and Establishing Benefits

Covered Beneficiaries and Eligible Participants

The Los Angeles County specialty SUD system is available to the safety net population, including individuals who are:

- Residents of Los Angeles County
- Medi-Cal eligible, including those served by local Medi-Cal managed care plans and their plan partners
- Those who are not Medi-Cal eligible but are participants in the My Health LA program
- Other low-income individuals who are concurrently participating in other County funded programs/projects such as California Work Opportunity and Responsibility to Kids (CalWORKs), General Relief, Department of Children and Family Services (DCFS), or Assembly Bill (AB) 109

Given that SUD services are carved out from Medi-Cal managed care plans, the specialty SUD system is responsible for the spectrum (mild to severe) of SUD treatment services, excluding:

- Early intervention (ASAM level 0.5), which is the responsibility of the managed care health plans
- Services provided in general acute hospitals, which are the responsibility of fee-for-service (FFS) Medi-Cal.

County of Responsibility

In accordance with State policy, the Los Angeles County specialty SUD benefit package follows a County of residence model of service delivery. As such, the County of responsibility for SUD services is the County of residence of the individual being served. Los Angeles County's specialty SUD benefit package is only available to Los Angeles County residents. SAPC network providers that render services to individuals whose County of Residence is not Los Angeles will not be reimbursed by Los Angeles County for those services. Only services rendered to individuals who have Los Angeles County as their County of Residence and are treated at a contracted site will be reimbursed.

Effective July 1, 2018, if a new referral or current continuing patient does not reside in Los Angeles County and does not intend to move, they need to be referred to a provider in their county of residence. Providers should provide out-of-county patients with the county of

residence phone number available at: <http://www.dhcs.ca.gov/individuals/Pages/DMC-CountyNumbersDirectory.aspx>.

Network providers who intend to deliver services to non-County residents must contract with the County where those beneficiaries reside to be reimbursed.

Out-Of-County Treatment Facilities

Effective July 1, 2018, SAPC contracted SUD treatment providers that operate a DMC-certified site in neighboring counties within California, may use those facilities to deliver services to eligible Los Angeles County beneficiaries. All contract requirements apply to out-of-county treatment facilities including but not limited to:

- All treatment requirements as outlined in this Provider Manual document and in the contractual arrangements for SUD treatment services.
- Pre-approval from SAPC to provide services. Services provided prior to approval may not be eligible for reimbursement.
- All certification and/or licensing requirements, including certifications by the California Department of Health Care Services (DHCS) and the Federal Drug Enforcement Administration (DEA).
- Inclusion of facility information (e.g., phone numbers, contact staff, hours of operations) in the contract.
- Site inspections at the discretion of SAPC. Providers may be required to reimburse the county for resources (e.g., travel and lodging) used to inspect out-of-County sites.

For additional information, contact your assigned Contract Program Auditor.

Opioid Treatment Programs (OTP) Courtesy Dosing

SAPC will reimburse courtesy dosing of methadone and buprenorphine for up to 30 days for OTP patients who are Medi-Cal beneficiaries and have traveled to Los Angeles County for business or leisure, and who do not qualify for, or are unable to bring enough take-home doses for the trip duration. The SAPC contracted provider must receive a courtesy dosing order from the home clinic that is signed by the medical director or program physician. The order form must outline dose, duration, and any other special instructions, such as take-home doses. Compliance with relevant Title 9 regulations is required.

For claims to be approved, providers must submit the Courtesy Dosing Reimbursement Form to SAPC. Required information includes the name, date of birth, Social Security Number (SSN), Medi-Cal Client Index Number (CIN), County/State of residence, home clinic, dates of service, medication type, health care procedure coding system (HCPCS), amount billed, and courtesy dosing reason. Individuals receiving courtesy doses are not entered as new admissions into Sage and data collection is not required. Claims must be submitted after the last dose is administered or distributed to the patient. The Courtesy Dosing and Reimbursement Form must be sent securely to cruiz@ph.lacounty.gov or via fax at (626) 299-7225 (Attention: DMC Unit).

Inter-County Transfers

In situations where the individual resides in Los Angeles County, but Medi-Cal benefits are assigned to another County, network providers conduct the screening/assessment and admit the patient for medically necessary services while Medi-Cal benefits are being transferred. Patients cannot be delayed or denied admission for eligible (i.e. Medi-Cal, My Health LA, AB 109) SUD treatment services due to incomplete or pending application and/or if Medi-Cal benefits are assigned to another County.

To initiate the transfer of benefits between counties, patients need to contact the public social services agency in the originating county. Patients will need to provide new physical and mailing addresses, and the primary contact number.

Ideally, this process will occur on the same day as Assessment/Intake, so services can be reimbursed under DMC. If patients are assisted by providers, services are reimbursable under Case Management (see the Case Management section for more information).

Visit <http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx> to find contact information for public social services agencies outside of Los Angeles County.

Eligibility Determination Process

Eligibility for Los Angeles County's specialty SUD benefit package must be verified by the SUD provider rendering services to patients. Eligibility for specialty SUD services in Los Angeles County includes the considerations outlined in **Table 3**.

Table 3. Eligibility Requirements for Specialty SUD Services in Los Angeles County

Eligibility Requirement		Source of Verification
Step 1	Resident of Los Angeles County and if Medi-Cal beneficiary, benefits are assigned to Los Angeles County.	Proof of residence (e.g., identification card, utility bill, etc.)
Step 2	<ul style="list-style-type: none"> • Medi-Cal Eligible or Enrolled <u>OR</u> • My Health LA Eligible or Enrolled <u>OR</u> • Participant in other qualified County funded programs/projects (e.g., AB 109) 	<ul style="list-style-type: none"> • Medi-Cal application submitted or Medi-Cal verification via MEDS file • My Health LA application submitted or proof of participation in My Health LA program (e.g., identification card) • Proof of participation in other qualified County funded programs/projects

<p>Step 3</p>	<p>Meets medical necessity criteria for specialty SUD services (see <i>Determining Medical Necessity</i> section of Provider Manual for additional information)</p>	<p>Completed ASAM Continuum or SAPC Youth ASAM assessment</p> <p>Adults (ages 21+)</p> <ul style="list-style-type: none"> • Must meet criteria for at least one diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders. <p>Youth (ages 12 – 17) and Young Adults (ages 18 – 20)</p> <ul style="list-style-type: none"> • Either meet criteria for the DSM criteria specified for adults; <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • Be determined to be “at-risk” for developing a SUD (see <i>Definition of At-Risk for Individuals up to Age 21</i> section for additional details).
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If a patient loses Medi-Cal eligibility while in treatment, and the treatment duration extends beyond the end of the month in which the termination occurred (as services would continue to be reimbursable by DMC during this period) the following should occur:

1. Determine if the patient is eligible for other funding sources (e.g., AB 109, CalWORKs, General Relief, Juvenile Justice Crime Prevention Act, Promoting Safe and Stable Families Time Limited Family Reunification, Title IV-E):
 - a. If yes – the patient’s treatment would move to the secondary funding source; this would apply to any level of care listed in the Rates and Standards Matrix.
 - b. If no – continued SAPC payment will depend on the level of care:
 - i. Residential (ASAM 3.1, 3.3, 3.5) – SAPC would pay for services for the remainder of service authorization period with other funds. If the agency elects to continue providing services to the patient beyond the service authorization period, it must be on a sliding scale basis with no financial participation by SAPC.
 - ii. Outpatient (ASAM 1.0-AR, 1.0, 2.1) – In instances where the agency elects to continue providing services to the patient, it must be on a sliding scale basis.
 - iii. Withdrawal management (ASAM 1-WM, 3.2-WM, 3.7-WM, 4-WM) – This situation is likely very rare since the maximum duration is 14-days. However, if this occurs, contact SAPC UM Division.
2. If the agency did not identify an alternate funding source in LACPRS/Sage, but the patient is actually eligible, providers will need to make that modification, so funding can be appropriately allocated.

Establishing Benefits and Delivering Concurrent Services

When an individual makes the decision to seek SUD treatment services, it is critical to provide services as soon as possible and to avoid any unnecessary barriers to care. In addition, it is likely that many individuals seeking care may be “eligible” for Medi-Cal or My Health LA but

whose benefits are not active at the time of assessment and intake. For these reasons, **eligible individuals may NOT be denied services pending establishment of Medi-Cal or My Health LA participation. Medi-Cal or My Health LA eligible beneficiaries/participants may NOT be charged sliding scale fees or flat fees.** Therefore, providers need to use the Case Management benefit to:

- Assist individuals obtain Medi-Cal or My Health LA if qualified but whose benefits are not active at the time of first contact. Providers should initiate the process on or before the date of first Treatment Service to better ensure reimbursement for delivered services.
- Assist Los Angeles County residents transfer Medi-Cal benefits to Los Angeles County if assigned to another County on or before the date of first Treatment Service. Reimbursement shall be denied for non-County residents.

For these individuals, Network Providers must also meet access to care requirements which necessitates that the date of first service or intake appointment occurs no later than 10 calendar days from the date of referral or screening.

To facilitate access to care, Network Providers will be **reimbursed** for delivered treatment services **for up to 60 days** after admission, assessment, and completion of CalOMS/LACPRS for:

- Patients who are likely eligible for My Health LA and whose complete application is submitted **but** not processed by the 60th day or it was ultimately denied by the County; and
- Patients who are undocumented and eligible for My Health LA but who refuse to participate in the program **if** a Miscellaneous Note was completed. The Miscellaneous Note must outline multiple efforts taken to encourage participation given advantages such as covered physical health services and detail the patient's refusal reasons. In general, this reason will be accepted provided the vast majority of eligible participants enroll.

Medi-Cal Eligible but Benefits Not Active

To facilitate access to care, Network Providers will be **reimbursed** for delivered treatment services **for up to 60 days** after admission, assessment and completion of CalOMS/LACPRS for:

- Patients who are likely eligible for Medi-Cal and whose complete Medi-Cal application is submitted with a Client Identification Number (CIN) number assigned **but** whose application was not processed by the 60th day or it was ultimately denied by the State; and
- Patients who need current Medi-Cal benefits re-assigned to Los Angeles County due to a permanent move and who submitted a transfer request to the County of residence **but** whose transfer was not processed by the 60th day.

If Medi-Cal benefits are ultimately established, SUD treatment services are reimbursable to the date of application. Therefore, it is essential to initiate this process as close to the date of first service as possible. It is also critical that:

- Individuals step-up or step-down to another level of care whenever clinically appropriate (e.g., from withdrawal management to outpatient) both to support improved and sustained recovery outcomes and to increase the time needed for patients to obtain health benefits; and

- The initial case manager communicates with the new case manager regarding the status of the patient's benefits application. The initial provider will rely on the subsequent provider to support the patient in completing the paperwork, so all are reimbursed once the application is approved.

Medi-Cal Managed Care

Medi-Cal managed care plans in LA County include L.A. Care and its delegated partners Kaiser Foundation Health Plan, Anthem Blue Cross, and Care 1st Health Plan; and Health Net and its delegated partner Molina Health Care. If the individual is a Medi-Cal beneficiary and has a member card from one of these health plans, they are entitled to the full SUD benefit package and thus should be referred to an appropriate Network Provider. It is then the treating provider's responsibility to coordinate care as appropriate with the Health Plan and/or their primary care physician.

Medi-Cal and Medicare: "Medi-Medi"

Dually eligible individuals, or those with Medi-Cal and Medicare, are entitled to the full DMC benefit package, including any County-specific supplemental services such as Recovery Bridge Housing. Medicare does not cover SUD services, and thus does not need to be billed first. Any Medicare associated share-of-cost cannot be collected before delivery of services.

Medi-Cal and Private Insurance

If the individual has private insurance (e.g., employer-sponsored, small group, or individual commercial insurance) and has Medi-Cal, the private insurance coverage must be fully utilized before Medi-Cal coverage can be accessed.

Medi-Cal and Share-of-Cost

Some Medi-Cal beneficiaries are required to share in the cost of their treatment services. These individuals must pay out of pocket until the share-of-cost (deductible) is met. This "spend down" is a clearance of the patient's share-of-cost liability. The patient must pay an amount towards medical expenses prior to receiving Medi-Cal benefits for that month.

Non-Medi-Cal Eligible Participants

The specialty SUD system in Los Angeles County is intended to serve individuals within the State and county safety net programs. Therefore, there may be times when individuals who are not eligible for either the My Health LA program or Medi-Cal (due to income that is above the allowable Medi-Cal threshold) seek services in the specialty SUD system.

If a patient participates in a County-funded program that provides additional funding to SAPC (i.e., AB 109, JJCPA, PSSP-TLFR, Title IV-E), patient can be admitted and served even if ineligible for Medi-Cal or My Health LA. The full benefit package is available to these patients at no-cost.

For patients who have commercial insurance and are ineligible for My Health LA, Medi-Cal, and other County-funded programs, SAPC is not responsible for reimbursement for services rendered for these patients. In these instances, SUD providers in Los Angeles County may serve these individuals and seek sliding scale reimbursement directly from the patient using the Client Fee Determination, as determined by the SUD provider.

Note: Sliding scale fees or flat fees are not allowable for Medi-Cal or My Health LA eligible beneficiaries or participants.

Access to Care

Access to care refers to the psychosocial and physical access to the location where treatment services are rendered. Physical barriers may include the architecture of the site, such as treatment providers with steps but no ramp entrance for disabled individuals. There may also be geographical or environmental barriers such as program locations that are inaccessible by public transportation, far from areas where patients live, or where patients do not feel safe. Lack of soundproofing in counseling offices and lack of privacy in assessment rooms are also potential barriers. Psychosocial barriers may include lack of communication capabilities for those who are non-English monolingual or limited English proficiency and hearing- or visually-impaired individuals, attitudes expressed by counselors or other staff that denote biases or communicate stigma to the patients, lack of a diverse workforce, operational hours that restrict access to services, or a lack of opportunity for patient input into his or her Treatment Plan or program operations.

While there is no “wrong door” to enter the specialty SUD system, there are three (3) main portals of entry:

- Toll-free Substance Abuse Service Helpline (SASH) at (844) 804-7500
- Client Engagement and Navigation Services (CENS)
- Direct-to-provider self-referrals

In all instances, maximizing access and minimizing the time and barriers to care are fundamental priorities for the specialty SUD system. Every effort must be made to minimize the elapsed time between the initial verification of eligibility, clinical need determination, referral, and the first clinical encounter.

Substance Abuse Service Helpline

One of the primary methods by which youth (ages 12 – 17), young adult (ages 18 – 20), and adult (ages 21+) patients can access specialty SUD services in Los Angeles County is by calling the Substance Abuse Service Helpline (SASH). Patients can call the SASH to initiate a self-referral or can be referred by an organization or another provider (e.g. law enforcement, family members, schools, and County departments). The SASH is available 24 hours a day seven (7) days a week. The primary functions of the SASH are to perform a brief, ASAM-based screening or triage assessment to determine an appropriate provisional level of care for an individual, and then to facilitate a successful referral and linkage to the identified provider capable of meeting the individualized needs of the patient.

[Substance Abuse Service Helpline](#) [\(844\) 804-7500](#)

The SASH helps individuals access specialty SUD services and is available 24/7.

Patients can call the SASH to initiate a self-referral for treatment. Individuals can also be referred to the SASH by an organization or others, including but not limited to, physical and mental health providers, law enforcement, family members, schools, and County departments.

Summary of SASH Process

1. Conduct eligibility and income verification to determine Medi-Cal or My Health LA eligibility and enrollment.
2. Conduct the screening using the electronic ASAM Triage Tool (for adults and young adults) or the Youth Engagement Screener (for youth).
3. Identify appropriate SUD providers via the Service and Bed Availability Tool (SBAT) and use the SBAT to identify available beds/intake appointments (see *Case Management* section for additional details).
4. Select an SUD provider based on a combination of patient preference and the clinical judgment of the SASH staff after conducting the screening to determine a provisional level of care determination. The SASH will be capable of providing referrals to programs that specialize in treating special populations (e.g., criminal justice, perinatal, co-occurring, LGBTQ) or specific cultural groups. The SASH will also leverage additional culture-based services such as interpretation services and services for the hearing- and visually-impaired.
5. Contact the selected provider to schedule the intake appointment while the caller or referring entity is on the line, except under limited circumstances (e.g., the caller's availability is unclear, after hours SASH calls, SASH staff are unable to schedule an appointment despite reasonable efforts).
6. Provide referral alternatives if the recommended provisional level of care is not available or a SUD provider that matches the caller's needs and preferences is not immediately available for an appointment.
7. Schedule the appointment (but need not occur) within three (3) business days from the date of the screening conducted by SASH staff (see **Table 4** for additional details of required access standard timelines). Unless the caller has specific provider or other preferences (e.g., cultural/linguistic specific services) that would require a longer waiting period, intake appointments and intake assessment with an appropriate SUD network provider must be scheduled and conducted within established timeframes from the date of the screening, as described in **Table 4** on page 31.

Connect with emergency services, if at any point during the call it is determined that emergency services are required. SASH staff will connect with 911 and remain on the line until emergency personnel have assumed responsibility for the call.

Sage will contain information related to referrals from SASH. Given that the information collected by the SASH is minimal, the information that SUD providers obtain from patient assessments at their site is deemed more comprehensive. However, if SUD providers want information from the SASH, they will need to obtain written consent from the patient to access this information.

SUD Treatment Agency Responsibilities in Receiving SASH Referrals

To receive referrals from the SASH the treatment agency must ensure the following:

1. The information within the SBAT must be updated by providers on at least a daily basis to reflect the number of beds and/or intake appointments that are available, and other required information. The treatment agency must also ensure that the SBAT includes current information on the days and hours of operation for each DMC-certified site, and any specialized expertise such as language capability or populations served.
2. Treatment agency staff must answer the phone number listed on the SBAT at all times during normal business hours and times when intake appointments are conducted (see

Hours of Operation section for additional details). Voicemail and extensive prompt systems are not acceptable alternatives to an individual answering the phone. It is critical that a live person answer because specific appointment times will be scheduled while the caller is on the line, whenever possible. If there is no response by the provider agency during these hours, SASH staff will proceed to the next treatment agency that meets the caller's needs and preferences.

3. While treatment agency staff may ask necessary screening questions to allow for acceptance of patients (e.g., questions to ensure treatment agency is able to accommodate patient needs, questions regarding arson or registered sexual offender status, etc.), treatment agency staff are prohibited from conducting a full ASAM triage screener when the SASH refers a patient to that treatment agency. SASH staff have already conducted a full ASAM triage screener prior to calling the treatment agency, and thus having treatment agency staff also conduct a full ASAM triage screener on the SASH referral call is duplicative and not patient-friendly given the goal to streamline the call and referral process for all involved. All efforts shall be made to limit the treatment agency screening process to 10 minutes or less.
4. Prior to the scheduled appointment, SUD treatment provider staff must call the referred individual to provide an appointment reminder, and/or call the individual if the appointment is missed.
5. If the full ASAM Continuum or SAPC Youth ASAM assessment conducted at the SUD treatment agency indicates that a different level of care is needed, the assessing SUD provider needs to connect the individual with the necessary and most appropriate level of care.
 - If the assessing treatment provider offers that level of care, and the facility meets the preferences and needs of the individual, the referral can be made internally.
 - If the assessing provider does not offer the necessary and most appropriate level of care, including if the assessing provider does not meet the geographic and other preferences of the individual, at least two alternative referral options need to be provided, whenever possible. The assessing provider needs to identify referral options using the SBAT tool and contact the selected provider to schedule an appointment on behalf of the individual.
6. In instances in which transitions between treatment and health providers are necessary, SUD treatment agency staff need to assist the patient with successfully connecting with the receiving treatment agency. Management of these transitions through case management is the responsibility of the referring treatment agency.
7. Documentation requirements apply to all treatment services, including interactions with the SASH.

Client Engagement and Navigation Services

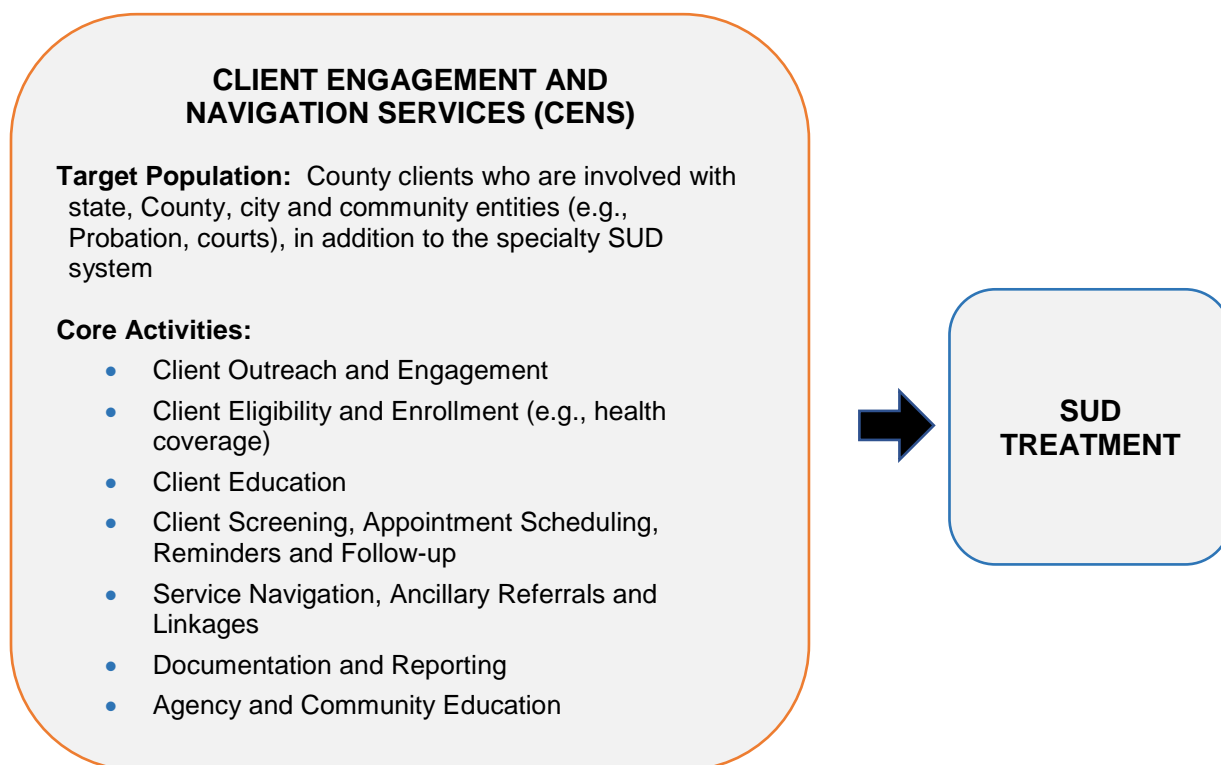
Given that many youth, young adult, and adult patients who receive SUD treatment services in the specialty SUD system are referred from state, County, city or community entities, it is important to ensure that these individuals are linked to SUD treatment. These individuals need more hands-on assistance to maximize treatment admission and retention and enhance the likelihood of positive outcomes, including obtaining employment, maintaining income benefits and housing, reuniting with children, and satisfying probation requirements or pre-plea/post-plea diversion from the court system. The CENS staff are SUD counselors that serve as liaisons between individuals involved with state, County, city, and community partners (e.g., Probation, courts) and the specialty SUD system. The CENS provides face-to-face services to facilitate access to and completion of SUD treatment.

Client Engagement and Navigation Service (CENS)

The CENS are SUD staff that serve as liaisons between individuals involved with state, County, city, and community partners (e.g., Probation, courts) and the specialty SUD system. The CENS provides face-to-face services to facilitate access to and completion of SUD treatment.

Core focuses of the CENS are highlighted in **Figure 3** and described in further detail below.

Figure 3. Client Engagement Navigation Services



Core Activities of the CENS

1) Client Outreach and Engagement

Although most clients are referred to a CENS site, some clients may be unable or unwilling to connect with the CENS at a co-located site. To connect these hard-to-reach individuals to SUD treatment services, the CENS may engage them in the field (e.g., streets, encampments, shelters, jails, etc.) at frequent and regular intervals to gain their trust and to motivate them to accept SUD treatment services. Outreach and engagement may take years and may require the CENS to repeatedly interact with the individual for brief periods to develop a rapport and trusting relationship that eventually leads to treatment engagement. Clients ready to accept SUD treatment services must then be immediately linked to the appropriate SUD treatment services. Client outreach and engagement are to be conducted based on need and at the direction and approval of SAPC.

2) Client Eligibility and Enrollment

The CENS is responsible for conducting eligibility and income verification to determine Medi-Cal or My Health LA eligibility and enrollment. The CENS must assist clients in entering data in the Department of Public Social Services YourBenefitsNow! (YBN) website for Medi-Cal enrollment or contacting a My Health LA provider to schedule an enrollment appointment. If the individual is eligible for Medi-Cal or My Health LA but coverage has lapsed, the CENS must initiate the necessary paperwork and refer the client to a qualified provider to continue the benefits enrollment process. This includes assisting with the transfer of Medi-Cal benefits when a client moves from another County and has established residency in Los Angeles County.

If a client referred to the CENS is not eligible for Medi-Cal or My Health LA, the CENS may provide referrals to SUD providers that accept clients on a sliding scale basis.

3) Client Education

When necessary and beneficial, the CENS must provide clients with a basic overview of SUDs and the treatment system to increase the likelihood of follow through with treatment initiation. Frequently, clients who are referred to the CENS for an SUD screening fail to understand the severity of their substance use problem. CENS staff must use Motivational Interviewing and Cognitive Behavioral Therapy techniques to engage and facilitate behavioral change in clients and encourage them to be more amenable to SUD treatment.

CENS staff must also:

- Discuss coping strategies with clients, including the steps to take in case of relapse
- Provide HIV/AIDS education and referrals for HIV testing and treatment
- Discuss the availability of medications for addiction treatment for their alcohol and opioid use disorders
- Discuss the availability of naloxone for overdose prevention

4) Client Screening, Appointment Scheduling, Reminders and Follow-up

The CENS will screen clients using the appropriate screener to determine whether referral to treatment is necessary. If treatment is needed, the CENS will schedule an assessment appointment at the agreed upon treatment provider. CENS are expected to call the individual to remind them of their appointment and to call them if they fail to show to their assessment appointment. CENS are also required to contact the treatment provider to determine the treatment status of the linked individual.

5) Service Navigation, Ancillary Referrals and Linkages

The CENS serves as a liaison between referring state, County, city, and community partner entities and SUD treatment agencies, ensuring that the referring entities are aware of the treatment status of their clients, including where clients are receiving treatment and anticipated treatment completion dates. CENS must communicate any treatment agency concerns or issues to the referring entities. For example, CENS staff co-located at the Los Angeles Superior Courts serve as court liaisons during regular court appearances or at the request of the bench officer and may provide client status reports on behalf of the treatment agency.

Navigation assistance and linkages to health and social service resources are important functions of the CENS and are particularly crucial when referring entities do not provide these needed services or cannot assist in connecting clients to these services.

Navigation and linkage services must include assistance with:

- Eligibility determinations
- Completing paperwork
- Appointment reminders and rescheduling missed appointments
- Providing or arranging for transportation to appointments
- Accompanying clients to their appointments to ensure optimal attendance and treatment retention

To support these functions, the CENS must establish and maintain cooperative linkages with other providers (e.g., public, private and other social, economic, health, legal, vocational and mental health partners) to make appropriate referrals that address unmet client needs. CENS staff must maintain a working knowledge and up-to-date resource directory that includes, but is not limited to, all SUD providers (via the SBAT), mental health providers, physical health providers and Medi-Cal managed care plans.

6) Documentation and Reporting

CENS staff must document their work in the electronic health record (EHR) for the specialty SUD system, known as Sage, and capture client service utilization, progress, and outcome information so this information can be reported to SAPC and the referring state, County, city, and community entities. Staff shall enter patient and service activities in partnering agencies electronic data collection systems, as appropriate (e.g., Treatment, Court, Probation, Exchange(TCPX), Homeless Management Information Systems (HMIS)).

7) Agency and Community Education

The CENS is responsible for the following agency and community education activities at the request and direction of SAPC:

- Conduct presentations for city/County/state entities on SUD prevention and treatment (to include needle exchange and overdose prevention) the SUD treatment system, and other requested topics.
- Conduct trainings about SUD treatment and the referral process into the specialty SUD system.
- Conduct community outreach to promote public awareness about SUDs and inform the community about available SUD treatment options.
- Participate in health and job fairs, as well as other community events, hosted by providers, faith-based organizations, hospitals, cities, the County, and others.

Location of CENS Activities

To improve access to SUD services, CENS has Area Offices located in each of the eight (8) Service Planning Areas (SPAs). CENS are also co-located at various state, County, city, and community sites to facilitate client entry into and navigation through the specialty SUD system.

The CENS are co-located at the following SAPC-approved sites:

- Los Angeles Superior Courts (e.g., Community Collaborative Court and Prop 47)
- Probation Department (e.g., Assembly Bill 109 HUBS and Adult Area Offices)
- Sheriff's Department (e.g., Community Re-entry and Resource Center, Twin Towers, Men's Central Jail)
- Department of Mental Health (DMH) Psychiatric Emergency Services (PES) and Urgent Care Centers (UCC)
- Homeless Encampments and Permanent Supportive Housing Sites
- Medical facilities, including Federally Qualified Health Centers and selected private and public hospital medical emergency rooms

Target populations served at these co-located sites include clients who are involved in the criminal justice system, uninsured, underinsured, homeless, and clients with co-occurring disorders.

During Fiscal Year 2018 – 2019, there will be one CENS lead provider per SPA that serves the entire SPA. SAPC may establish additional co-located sites based on need and funding availability in the future. CENS providers may also request additional CENS co-locations (See attached CENS Co-locations Procedures).

Lead CENS agencies may continue to subcontract with other providers to ensure SPA-wide coverage, as approved by SAPC.

To support CENS objectives, all co-located sites must carry out activities in a uniform manner to establish measurable and successful linkages to SUD treatment and other necessary services.

CENS Staffing

The CENS will employ, at minimum, registered and/or certified SUD counselors who utilize a patient-centered and biopsychosocial approach to assist clients in accessing SUD treatment and other ancillary services. Licensed Practitioners of the Healing Arts (LPHAs) may also be

utilized by the CENS (see *Workforce* section and *Staffing Grid* in the Network Provider Section on the SAPC website for additional details).

Hours of Operation

Hours of operation will vary depending on CENS staffing patterns and client volume. Some CENS locations will not have full-time staff due to lower client volume, and scheduled days/times will reflect this. However, for co-locations with full-time CENS staff, staff must be available Monday through Friday from 8:00 AM to 5:00 PM.

CENS Referral Process

Referrals to the CENS may come from various state, County, city, and community entities. The CENS must make every attempt to meet with the referred client on the day of the referral. The CENS must notify the referring entity if the client cannot be seen on the day of the referral and must provide the date of the screening and referral appointment. For referring entities with co-located CENS sites, the referral process consists of three (3) main steps:

1. Screening
2. Appointment Scheduling and Follow-Up
3. Service Navigation

State, County, city, and community entities that do not have a co-located CENS site should refer clients in need of SUD treatment to the SASH (see *Substance Abuse Service Helpline* section for additional details) or direct-to-provider.

1) Screening Process

- Determine eligibility status for specialty SUD services in Los Angeles County (see Step 1 and 2 of **Table 3** on page 19).
- Perform screening to determine provisional level of care need of the client:
 - **Youth (ages 12 – 17)** –Use the Youth Engagement Screener. If results indicate that the assessed youth is at-risk of developing an SUD or would likely meet medical necessity for specialty SUD services, an appointment must be scheduled with an outpatient youth treatment agency to administer the full SAPC Youth ASAM assessment, and At-Risk Determination Tool as necessary. **Young adults (ages 18 – 20) and Adults (ages 21+)**– Use the ASAM Triage Tool (ATT). If results indicate the individual would likely meet medical necessity for specialty SUD services, an appointment must be scheduled with an appropriate SUD treatment provider, as determined by use of the Service and Bed Availability Tool (SBAT).
- If screening results indicate treatment is necessary, but the patient is not willing to follow through, CENS staff must advise the patient about harm reduction measures such as needle exchange, overdose prevention, and other steps that may reduce negative consequences.
- If the screening results do not indicate a need for further assessment or receipt of covered SUD services, CENS staff must coordinate with the case worker from the referring entity to close the case or identify alternative options (e.g., prevention or brief intervention services) available in the community or offered by the Medi-Cal managed care plan provider.
- The CENS may also conduct additional screening assessments for ancillary service referrals if they have not already been conducted by the referring case worker (e.g., vocational rehabilitation, educational needs, housing, other public social services).

- After the CENS conducts the screening or triage assessment, it will schedule an appointment for a full ASAM Continuum or SAPC Youth ASAM assessment with a SUD treatment provider that matches the client's needs and preferences using the SBAT.

2) Appointment Scheduling Process

- Once the CENS conducts the screening and determines likely eligibility and need of specialty SUD services, an appointment must be scheduled with an appropriate SUD treatment provider.
- The SBAT will be used to help identify providers that meet the individualized needs of the individual. CENS staff will enter the preferred service location in the SBAT, as well as the provisional level of care and specific language, population (e.g., criminal justice involved, perinatal, homeless, LGBTQ), and/or service (e.g., medication for addiction treatment, perinatal) preferences.
- CENS staff should make reasonable efforts to offer the client at least two (2) appropriate SUD treatment provider options.
- As part of the appointment scheduling process, the CENS is responsible for the following activities:
 - Contact the selected treatment provider with the individual to schedule an appointment time.
 - Briefly describe what to expect when arriving at the SUD treatment provider site, the description of the level of care identified, and the contact information for the facility.
 - Encourage clients to sign consents to release information and allow the CENS to communicate directly with the assigned SUD treatment provider and referring state/County/city/community entity.
 - Document relevant information into Sage, the electronic health record (EHR) for the specialty SUD system.
 - Contact clients to remind them of their upcoming assessment appointments and coordinate and/or provide transportation to the treatment provider, if needed.
 - The CENS will provide SUD treatment providers with tracking forms to be faxed or emailed back to the CENS, confirming that clients kept their scheduled appointments, rescheduled their appointments, or failed to keep their appointments.
 - Confirm that clients are enrolled in SUD treatment programs as agreed upon with referring entities and report client status back to the referring entity through relevant data entry systems, as directed by SAPC.
 - Contact 911 if at any point during the meeting it is determined that emergency services are required, remaining with the individual until emergency personnel arrives.

3) Service Navigation

CENS are expected to maintain a working knowledge and up-to-date resource directory that includes, but is not limited to, all SUD, mental health, and HIV/AIDS providers and approved HIV trainings to fulfill requirements for mandatory HIV/AIDS trainings.

4) Documentation and Reporting

CENS staff must enter client service utilization, progress, and outcome information in the electronic health record (EHR) known as Sage, and other data collection systems such as Treatment, Court, Probation, Exchange (TCPX) and Homeless Management Information Systems (HMIS).

SUD Treatment Agency Responsibilities in Receiving CENS Referrals

See responsibilities in the *SUD Treatment Agency Responsibilities in SASH referrals* section.

Direct-to-Provider

Individuals seeking specialty SUD services in Los Angeles County can go directly to or contact an SUD treatment agency to initiate services, and therefore are not required to contact the SASH or CENS to access specialty SUD services. Oftentimes, individuals will identify providers based on word-of-mouth in the community, prior experiences, or by consulting the SBAT for information about specialty SUD providers throughout the County.

Staffing

See minimum staffing requirements in the *Workforce* section.

Hours of Operation

See **Table 5** for guidance on minimum hours of operation.

SUD Treatment Agency Process and Responsibilities in Receiving Direct Self-Referrals

Treatment agencies MUST:

1. Update the information within the SBAT on at least a daily basis to reflect the number of beds and/or intake appointments that are available, and other required information. The treatment agency must also ensure that the SBAT includes current information on the days and hours of operation for each DMC-certified site, and any specialized expertise such as language capability or populations served.
2. Have treatment agency staff answer the phone number listed on the SBAT at all times during normal business hours and times when intake appointments are conducted (see *Hours of Operation* section for additional details). Voicemail and extensive prompt systems are not acceptable alternatives to an individual answering the phone. It is critical that a live person answers calls at the treatment provider site because specific appointment times will be scheduled by the SASH or CENS in real-time, whenever possible. If there is no response by the provider agency during these hours, SASH and CENS staff will proceed to the next treatment agency that meets the caller's needs and preferences.
3. **Treatment provider sites that offer the full SUD continuum of care**
Triaging patients via the screening is less critical for SUD treatment sites that offer the full SUD continuum. No matter what level of care an individual may need, the treatment provider site would be able to offer that level of care and meet the identified needs. As such, when patients present to SUD treatment sites that offer the full SUD continuum of care, the initial assessment conducted may be the full ASAM Continuum or SAPC Youth ASAM assessment (see *Assessment* section for additional details).

4. **Treatment provider sites that do NOT offer the full SUD continuum of care**

Administer either the Youth Engagement Screener (ages 12 – 17) or ASAM Triage Tool (ages 18+) to prevent scenarios in which patients are taken through a full ASAM assessment only to realize that the assessing treatment site does not offer the level of care needed to meet the patient's needs.

- Starting with a screening ensures a patient-centered approach to the intake process and reduces the likelihood that treatment provider sites will invest resources in a full ASAM Continuum or SAPC Youth ASAM assessment that are later not reimbursable if patients do not meet medical necessity for the level(s) of care offered at that treatment provider site.

5. Assist the patient with successfully connecting with the receiving treatment agency in instances in which transitions between levels of care or treatment and health providers are necessary, including instances in which the assessing provider sites does not meet the geographic and other preferences of the individual. Management of these transitions through case management is the responsibility of the last treatment provider.

Service and Bed Availability Tool and Provider Directory

The Service and Bed Availability Tool (SBAT) is a web-based tool that provides a dashboard of available specialty County-contracted SUD services throughout Los Angeles County, including: outpatient and intensive outpatient, various levels of residential treatment and withdrawal management, OTPs, Recovery Bridge Housing (RBH), and Driving Under the Influence (DUI) programs.

The purpose of the SBAT is to help achieve the aim of a more organized SUD delivery system by simplifying the process of identifying appropriate SUD providers. By allowing users to filter their search based on the levels of care, languages spoken, and types of services delivered, users can tailor their search according to their need, and more quickly identify intake appointment times and available residential and RBH beds.

To add a DMC-certified agency-operated treatment site to the SBAT, agencies must first complete the *Provider Directory Survey*. Once this is complete and the site is added to the SBAT, the actual number of outpatient and intensive outpatient intake appointments/slots and residential/inpatient and residential/inpatient withdrawal management intake appointments/beds needs to be updated at least daily.

Since the SASH, CENS and public will use the SBAT to identify which treatment agency and location to contact for services, it is critical to update and verify the information provided in the survey. Information on beds/slots availability and intake appointments must be updated in the SBAT, as required.

If the slots/beds are not updated by 10:00 AM Monday through Friday, the system will automatically display an availability of zero (0) until the information is updated.

The following information is needed to estimate the total available intake appointments per day:

1. Number of individuals available to conduct assessments
2. Number of hours each day an individual can conduct assessments
3. Average appointment duration

4. Number of slots/beds available so treatment services can begin immediately
More detailed instructions about using the SBAT are available on the SAPC website.

Example: How to Calculate Intake Appointment Slots

Number of Intake Appointment Slots = (Available Staff X Dedicated Hours) / Average Intake Time

A treatment site employs 5 full-time SUD counselors who are required to conduct direct treatment services for at least 4 hours with a one-hour lunch break. On average, it takes 2 hours to conduct the screening, benefits determination and enrollment assistance (if applicable) process, and confirm preliminary eligibility for services (not all intake and assessment paperwork needs to be completed on the same day). Therefore, based on an 8-hour workday the site could enter 10 available appointments into SBAT for that day:

$$(5 \text{ staff} \times 4 \text{ available hours for appointments}) \div 2 \text{ hours per appointment} = 10 \text{ intake slots that day}$$

If all clinical staff have a full caseload and are not accepting new patients, except one who has space for 2 new patients, the available appointments should be listed as 2, not 10. This is because patients cannot be screened/assessed and placed on a waitlist for direct treatment services.

Timeliness and Access Standards

Ensuring timely access to services is essential to accomplish the aim of improving outcomes of the specialty SUD system, as is engaging patients when they are ready to initiate treatment.

In addition to time, distance is another component of treatment access that has been linked to patient outcomes. Generally, the shorter the distance between a patient and his/her treatment site, the better the patient outcome. Unless otherwise requested by the patient, every effort must be made to refer the patient to a treatment program that is within 30 minutes of travel time by personal or public transportation or fifteen (15) miles from the patients' location of choice (see **Table 4**). If this is not feasible, every effort should be made to decrease the likelihood that the commute or transportation issues serve as a barrier to accessing treatment. If patients prefer to have some aspect of treatment delivered in a different region than where they reside or work, this preference must be considered and noted in their clinical record.

Table 4. SAPC Access and Services Delivery Standards

SERVICE	DUE DATE
Distance Standards for Referrals	Every effort must be made to refer patients to a treatment program within (1) 30 minutes of travel time by personal or public transportation or (2) 15 miles from the patients' location of choice
Screening for Provisional LOC* *If the agency does not offer the provisional LOC or a Slot/Bed will not be available within 10 days, referrals must be provided (no waitlists allowed)	Date of first contact (walk-ins only) Provide two alternate referral agencies and connect the patient within 48 hours to the preferred provider
Assessment Appointment - Scheduled	Immediately but no longer than 3 calendar days of screening/referral (Note: SASH may move to the next provider if no immediate response or available appointment).
Assessment Appointment - Conducted	Within 10 business days of screening/referral
County Residency Eligibility Verification	Date of first service/intake appointment*
Medi-Cal or MHLA Eligibility Verification	
Patient Handbook Provided	
Notice of Policy Practice Provided	
Notice of Privacy Practices	Within 5 calendar days of first service or first intake appointment
ASAM Continuum or SAPC Youth ASAM Assessment	Within 7 calendar days of first service or first intake appointment* for adults (18+)
Medical Necessity Determination	OR Within 14 calendars days of first service or first intake appointment* for youth (ages 12-17)
Data Submission (CalOMS/LACPRS)	<i>If every attempt has been made to complete and finalize the ASAM within the 7 or 14 calendar day timeframe, but circumstances do not allow for full completion, then the provider must include a Miscellaneous Note detailing the reason for the inability to meet the established standard.</i>
Treatment Plan (Initial Only)	Within 7 calendar days of first service or first intake appointment* for adults (18+), including signatures by both patient and LPHA OR Within 14 calendars days of first service or first intake appointment* for youth (ages 12-17) including signatures by both patient and LPHA <i>If every attempt has been made to complete and obtain signatures within the 7 or 14 calendar day timeframe, but</i>

	<p><i>circumstances do not allow for full completion, then the provider must:</i></p> <ul style="list-style-type: none"> • Include a Miscellaneous Note with justification detailing what prevented completion within the timeframe; • Complete an initial Treatment Plan based on the information (and signatures) available at the 7 or 14 calendar day deadline; and • Within 30 days (28 for OTP) of first service or first intake appointment, * complete a Treatment Plan based on the assessment, that includes all elements and is signed by the patient and LPHA. The LPHA or Medical Director must then sign the Treatment Plan within 15 days of the patient signing.
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To optimize access to SUD services, SUD treatment agencies must implement an ongoing, systematic evaluation process for identifying physical and/or psychosocial access issues that may impede SUD treatment seeking behavior. The evaluation process should identify counselor/staff attitudes around substance use, patient transportation, or any other accessibility issues. Providers must also consider patient and stakeholder feedback during this process. Once barriers are identified, SUD treatment agencies should develop a plan detailing how they plan to address the identified barriers. The plan may be a Quality Improvement Project (see section titled *Providers – Quality Improvement & Utilization Management Expectations* for additional information) that specifies the barrier(s) and action(s) that will be taken to eliminate or reduce the impact of the barrier, and when these specific actions will be completed.

Hours of Operation by Benefit

Table 5. Hours of Operation by Benefit

Benefit	Applicable Levels of Care	Minimum Hours of Operation*
Outpatient Levels of Care	<ul style="list-style-type: none"> - Outpatient (ASAM 1) - Intensive Outpatient (ASAM 2.1) - Ambulatory (Outpatient) Withdrawal Management without Extended On-Site Monitoring (ASAM 1-WM) 	<ul style="list-style-type: none"> - Must operate at least five (5) days a week (including either one 8-hour day on Saturday or Sunday; or a 4-hour day on Saturday and 4-hour day on Sunday); AND - At least two (2) days must include evening hours (5:00 PM to 9:00 PM, at a minimum)
Residential and Inpatient Levels of Care	<ul style="list-style-type: none"> - Clinically Managed Low-Intensity Residential Services (ASAM 3.1) - Clinically Managed Population-Specific High-Intensity Residential Services (ASAM 3.3) - Clinically Managed High-Intensity Residential Services (ASAM 3.5) - Clinically Managed Residential Withdrawal Management (ASAM 3.2-WM) - Medically Monitored Inpatient Withdrawal Management (3.7-WM) - Medically Managed Intensive Inpatient Withdrawal Management (4-WM) 	<ul style="list-style-type: none"> - Must operate 24 hours per day, seven (7) days a week; AND - Must accept intakes at least during regular weekday business hours (9:00 AM to 5:00 PM, at a minimum)
Opioid Treatment Program	<ul style="list-style-type: none"> - Opioid Treatment Programs (1-OTP) 	<ul style="list-style-type: none"> - Must operate at least five (5) days a week (including either one 8-hour day on Saturday or Sunday; or a 4-hour day on Saturday and 4-hour day on Sunday)
Recovery Bridge Housing	<ul style="list-style-type: none"> - Recovery Bridge Housing 	<ul style="list-style-type: none"> - Must operate 24 hours per day, seven (7) days a week; AND - Must accept intakes at least during regular weekday business hours (9:00 AM to 5:00 PM, at a minimum)
* Hours of operation standards do not apply to approved field-based services locations.		

The minimum and maximum number of hours per week do not change for weeks that include a federal, state or local holiday. The County, however, will consider this during administrative reviews and during monitoring visits. In general, this would not be an audit exception, provided the week prior and the week after the holiday meets minimum and maximum standards.

For intensive outpatient programs, the rate will be lowered to the outpatient rate for any claims associated with an individual who does not receive the minimum number of service hours/units in any week.

Determining Medical Necessity

Medical necessity is a standard applied to justify services as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.

Medical necessity must be consistently applied to ensure equitable access to services, must be established to demonstrate and maintain DMC eligibility, and must also be established for provided services (e.g., residential treatment, Recovery Bridge Housing, etc.).

Medical necessity can only be determined **after** a full ASAM Continuum or SAPC Youth ASAM assessment, which includes an SUD diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM), is finalized. Screenings do not include sufficient information to determine medical necessity because they do not include a DSM diagnosis determination or contain sufficient information regarding the six (6) ASAM dimensions to constitute a comprehensive biopsychosocial ASAM assessment.

Definition of Medical Necessity

To meet medical necessity criteria, patients must meet the following two (2) criteria:

1. Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis

- Youth (ages 12 – 17) and Young Adults (ages 18 – 20)
 - Either meet criteria for the DSM criteria specified for adults;
OR
 - Be determined to be at-risk for developing a SUD (see *Definition of At-Risk for Individuals up to Age 21* section for additional details).
- Adults (ages 21+)
 - Meet criteria for at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

2. American Society of Addiction Medicine (ASAM) treatment criteria for services

Patients must meet the ASAM treatment criteria for services, including the ASAM adolescent treatment criteria, when applicable.

Medical necessity encompasses all six (6) ASAM dimensions and takes into consideration the extent and biopsychosocial severity of the various dimensions within the full ASAM Continuum or SAPC Youth ASAM assessment. Medical necessity must not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1), acuity of physical health needs (as in Dimension 2), or Dimension 3 psychiatric issues (such as imminent suicidality).

Definition of At-Risk for Individuals up to Age 20

Youth (ages 12 – 17) and Young Adults (ages 18 – 20) in the specialty SUD system are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Eligibility for EPSDT broadens the definition of medical necessity for youth to include individuals who are deemed “at-risk” for SUDs and makes the full SUD benefit package available to all individuals up to age 20 without any caps or limitations, assuming medical necessity is established.

It is important to note that federal EPSDT requirements supersede state Medi-Cal requirements, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver does not override EPSDT.

Medical Necessity for Youth (ages 12 – 17) and Young Adults (ages 18 – 20)

To be eligible for specialty SUD services included within the EPSDT Medi-Cal benefit, substance use services must be deemed medically necessary by a Licensed Practitioner of the Healing Arts (LPHA), or a counselor (registered or certified) with signature approval from an LPHA. Medical necessity will be determined using a SAPC Youth ASAM assessment for each Medi-Cal-eligible youth (ages 12 – 17) or a full ASAM Assessment (ASAM Continuum or SAPC-approved full ASAM assessment) for young adults (ages 18 – 20). Given developmental considerations, the SAPC Youth ASAM assessment will be used to determine medical necessity for youth whereas the electronic full ASAM Continuum assessment will be used for young adults.

To meet medical necessity for specialty SUD services, youth and young adults under the age of 21 must meet at least one of the following criteria:

1. Have at least one diagnosis from the current Diagnostic and Statistical Manual (DSM) of Mental Disorders for Substance-Related Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-related disorders, and meet the ASAM Criteria for necessary services

OR

2. Be assessed to be “at-risk” for developing a substance use disorder

Definition of “At-Risk” for Youth (ages 12 – 17) and Young Adults (ages 18 – 20):

Youth or young adults under the age of 21 may be determined to be “at-risk” if they meet the following criteria:

1. If the substance use does NOT meet the minimum criteria for a substance use disorder from the DSM-5 (with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders)

AND

2. Determined to be at-risk of developing a substance use disorder based on reports of experimental or early-phase substance use, associated biopsychosocial risk factors, and information gathered from the full ASAM Continuum or SAPC Youth ASAM assessment and At-Risk Determination Tool

As a result, the “at-risk” designation is a component of medical necessity for youth and young adults, and must be either determined by an LPHA, or a counselor (registered or certified) with signature approval from an LPHA. Upon an “at-risk” determination, youth and young adults are eligible for short-term intervention services under ASAM 1.0-AR level of care (e.g., counseling and case management) for their substance use through the EPSDT Medi-Cal benefit. These services are low-intensity, limited to 40 units of service (in 15-minute increments; totaling 10 hours), and must be provided in outpatient SUD settings. Additional details are included in **Table 6** below.

Table 6. Short-Term Services Available to Youth (ages 12 – 17) and Young Adults (ages 18 – 20)

Medical Necessity Determination	Level of Care	Services	Recommended Time/Units of Service
Youth (ages 12 – 17)	Outpatient At-Risk	Completion of Youth Engagement Screener	15 minutes
		Completion of Full SAPC Youth ASAM Assessment	60 minutes
		Completion of intake and abbreviated Treatment Plan	45 minutes
		Conduct interventions, including patient education/individual and group counseling/case management, to address treatment goals	120 minutes (30-minute sessions)
Young Adults (ages 18 – 20)	Outpatient At-Risk	Completion of ASAM Triage Tool	15 minutes
		Completion of Full ASAM Assessment (ASAM Continuum or SAPC approved full ASAM assessment)	60 – 90 minutes
		Completion of intake and abbreviated Treatment Plan	45 minutes
		Conduct interventions, including patient education/individual and group counseling/case management, to address treatment goals	90 – 120 minutes (30-minute sessions)

Process for Determining Medical Necessity

Who is considered an LPHA?

- Physician
- Nurse Practitioner
- Physician Assistant
- Registered Nurse
- Registered Pharmacist
- Licensed Clinical Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Clinical Counselor
- Licensed Marriage and Family Therapist
- Licensed-Eligible LPHA:
Working under the supervision of a licensed clinician

Verification of Medical Necessity

Medical necessity must be verified by a Licensed Practitioner of the Healing Arts (LPHA) via a face-to-face review with the individual conducting the assessment (e.g., SUD counselor). The face-to-face review must at minimum involve the LPHA verifying and signing off on medical necessity in a face-to-face collaboration with the SUD counselor who conducted the assessment. The review may include the patient, although it is not required.

The LPHA is required to document separately from the Treatment Plan the basis for the diagnosis in the form of a Miscellaneous Note within thirty (30) calendar days of each patient's treatment admission date. The basis for the diagnosis should include a statement that the patient's personal, medical, and substance use history were reviewed. The Miscellaneous Note must be signed and dated, then submitted in the patient record in Sage.

Timeliness of Medical Necessity Determination

The LPHA must determine medical necessity within 7 calendar days of first service/first intake appointment for adults (18+) or within 14 calendar days of first service/first intake appointment for youth (ages 12-17). The basis for the diagnosis and medical necessity must be documented within the individual patient records.

If every attempt has been made to establish Medical Necessity within the 7 or 14 calendar day timeframe, but circumstances do not allow for full completion, then the provider must include a Miscellaneous Note detailing failure to meet the established standard.

Timeliness of Medical Necessity Re-verification

For each patient to receive ongoing SUD services, the LPHA must determine medical necessity for continued services for each patient no sooner than five (5) months and no later than six (6) months after the beneficiary's treatment admission date. or from the last justification. The justification of medical necessity must be documented in a Miscellaneous Note and include information on the following:

1. Description of the patient's personal, medical, and substance use history
2. Most recent physical exam
3. Progress Notes and Treatment Plan goals
4. The LPHA's or counselor's recommendation for continued treatment
5. Patient progress toward treatment goals

The Miscellaneous Note must be signed and dated by LPHA, then submitted in the patient record in Sage.

Assessment

Assessments are the evaluation, measurement and documentation of patients to determine diagnoses and service needs. In the treatment of persons with SUDs, assessments are an ongoing process and are essential to identify patient needs and help the provider focus their services to best meet those needs. Assessments are also important opportunities for patient engagement and Treatment Planning. Assessments are generally performed in the initial phases of treatment, though not necessarily during the initial visit.

Comprehensive, validated, and standardized assessments tools, and their corresponding documentation, form the foundation of high quality SUD services. Assessments based on the ASAM Criteria ensure that there is a standardized structure by which to collect necessary clinical information to make appropriate SUD level of care determinations. Assessments need to be appropriately documented (see *Documentation* section for additional details), reviewed, and updated on a regular basis, including at every care transition, to promote engagement and meet the patient's needs and preferences.

If while assessing the patient the provider determines that adequate progress toward treatment goals has been made, plans to build upon these achievements need to be made, which may include transitions to other services and recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals need to be performed if progress toward agreed upon goals is not being made within a reasonable time.

LPHAs and SUD counselors must have the appropriate experience and training before conducting both screening, assessment, and medical necessity determinations.

Screening Tools

Screenings are abbreviated evaluations of individuals that allows for a provisional determination about if and what types of additional SUD services are necessary and appropriate. These abbreviated assessments are less comprehensive than full assessments and thus do not replace full assessments but are meant to provide a reasonable estimation of the type and intensity of SUD services that will be necessary to meet an individual's needs.

Screenings do not contain sufficient information to determine medical necessity because they do not include a DSM diagnosis determination and contain insufficient information regarding the six (6) ASAM dimensions to constitute a comprehensive biopsychosocial ASAM assessment.

Allowable Screening Tools

- Youth (ages 12 – 17)
 - Youth Engagement Screener developed by SAPC (paper-based)
 - Parent Screener for Youth developed by SAPC (paper-based)
- Young Adults (ages 18 – 20) and Adults (ages 21+)
 - ASAM Triage Tool (validated electronic tool)
 - SAPC-approved paper-based brief ASAM triage assessment

Assessment Tools

Full ASAM assessments include a comprehensive evaluation of the six (6) dimensions of the ASAM Criteria, in addition to other important clinical elements captured during the assessment interview.

Medical necessity must be determined by a full ASAM Continuum or SAPC Youth ASAM assessment and not solely by a screening. Full ASAM assessments include a determination if an individual meets the diagnostic criteria for a SUD from the DSM-5.

Allowable Full ASAM Assessment Tools

- Youth (ages 12 – 17)
 - SAPC Youth ASAM assessment
- Young Adults (ages 18 – 20) and Adults (ages 21+)
 - ASAM Continuum (validated electronic tool)
 - SAPC-approved paper-based full ASAM assessment

Service Benefit and Levels of Care

Addiction treatment is delivered across a continuum of services that reflect illness severity and the intensity of services required. One of the key goals of the County is to facilitate SUD service delivery that is the right service, at the right time, for the right duration, in the right setting. The levels of care need to be viewed as points along a continuum of treatment services, each of which may be provided in a variety of settings.

Referral to a specific level of care must be based on a comprehensive and individualized assessment of the patient, with the primary goal of placing the patient at the most appropriate level of care. Initial referrals may be accomplished through a brief screening tool with a more comprehensive assessment completed at the treatment program to confirm placement. In Los Angeles County, level of care determinations are based on the ASAM Criteria to organize the assessment and clinical formulation to provide more consistency in level of care determinations. In general, the preferable and most appropriate level of care is one that is the least intensive while still safely meeting the unique treatment objectives of the patient and treatment team.

Level of care determinations begin with the full ASAM multidimensional assessment, which explores patient risks, needs, strengths, skills, and resources. Dimension-specific risk ratings are generated from the assessment process and are used to help inform providers as to dimensional priorities, which are subsequently used for service planning and placement. When physical or mental health conditions are apparent, the need for immediate stabilization should be prioritized and the highest severity problem should determine the patient's entry point into the treatment continuum, whether it is within the SUD system of care (including Opioid Treatment Programs), or in the physical or mental health systems. Treatment is best conceptualized as a flexible continuum, marked by different ASAM levels of care, with gradations of service intensities for residential and withdrawal management services (see **Table 7**).

Table 7. SUD Continuum and Levels of Care

SUD CONTINUUM AND LEVELS OF CARE		
Benefits	ASAM Level of Care	Description
Outpatient	1.0	Appropriate for patients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.
Intensive Outpatient	2.1	Appropriate for patients with minimal risk for acute intoxication/withdrawal potential, medical, and mental health conditions, but need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting.
Low Intensity Residential (Clinically Managed)	3.1	Appropriate for individuals who need time and structure to practice and integrate their recovery and coping skills in a residential environment.
High Intensity Residential, Population Specific (Clinically Managed)	3.3	Appropriate for patients with functional limitations that are primarily cognitive, who require a slower pace to treatment, and are unable to fully participate in the social and therapeutic environment
High Intensity Residential, Non-Population-Specific (Clinically Managed)	3.5	Appropriate for patients who have specific functional limitations and need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances
Opioid Treatment Program	1-OTP	Appropriate for patients with an opioid use disorder that require methadone or other medication-assisted treatment.
Recovery Bridge Housing	N/A	Appropriate for patients who are homeless or unstably housed; and are concurrently enrolled in an outpatient, intensive outpatient, opioid treatment program, or ambulatory withdrawal management levels of care.

SUD CONTINUUM AND LEVELS OF CARE		
Benefits	ASAM Level of Care	Description
Recovery Support Services	N/A	Appropriate for any patient who has completed SUD treatment.
Ambulatory (Outpatient) Withdrawal Management	1-WM	Appropriate for patient with mild withdrawal who require either daily or less than daily supervision in an outpatient setting.
Clinically Managed Residential Withdrawal Management	3.2-WM	Appropriate for patient with moderate withdrawal who need 24-hour support to complete withdrawal management and increase the likelihood of continuing treatment or recovery.
Medically Monitored Inpatient Withdrawal Management	3.7-WM	Appropriate for patients with severe withdrawal that requires 24-hour inpatient care and medical monitoring with nursing care and physician visits.
Medically Managed Inpatient Withdrawal Management	4-WM	Appropriate for patients with severe withdrawal that requires 24-hour nursing care and physician visits to modify withdrawal management regimen and manage medical instability.
Source: American Society of Addiction Medicine		

Note: Currently the SAPC provider network does not provide Level 3.7 and 4.0 Intensive Inpatient Services; it only offers 3.7-WM and 4-WM. If the patient screens for level 3.7 or 4.0 Intensive Inpatient Services, then the provider may consider the following options as clinically appropriate:

- Refer the patient to level 3.7 Withdrawal Management or 4.0 Withdrawal Management, as medically necessary.
- Refer the patient to a general acute hospital for medical treatment or an inpatient psychiatric hospital if the patient requires psychiatric treatment.
- Consider a referral to a residential setting, as clinically appropriate.

Opioid Treatment Programs (OTPs; aka Narcotic Treatment Programs) are an essential component of the continuum of care for substance use disorders. As with other levels of SUD care, ensuring a flow of appropriate referrals between OTPs and other SUD providers, and appropriate referrals into other health systems (if needed), are all critical to high quality OTP services. As such, in addition to the various State and Federal requirements that govern OTPs, the quality and resource management standards and requirements set within the Quality Improvement and Utilization Management (QI and UM) program also pertain to OTPs.

The ASAM Criteria also outlines a continuum of care for withdrawal management (also known as detoxification) for adults. Given that severe withdrawal is less common in adolescents than in adults, the approach to withdrawal management for adolescents is unique. When adolescent physiologic withdrawal is evident and when the clinical scenario does not require emergent care, a more integrated approach is ideal, and every effort should be made to provide withdrawal management services in the setting in which adolescent patients are receiving their SUD care. Withdrawal management for adolescent populations will be approved by SAPC on a case-by-case basis.

In cases in which the recommended level of care is not available, which can occur due to a variety of reasons (lack of availability, funding limitations, resource constraints, etc.), the

Treatment Plan needs to be revised to provide needed services in a different placement. Effectiveness and safety should be first priority in these circumstances, which may require that patients be placed in higher levels of care than the ASAM Criteria indicates. In these instances, it is the providers' responsibility to advocate for the patient and justify and explain the rationale for the alternative level of care or intervention, based on the available clinical documentation.

Services provided at the various levels of care should reflect the patient's clinical condition, including consideration for severity level and functional impairment. Interventions may include, but are not limited to: individual counseling, group counseling, family therapy, patient education, psychosocial interventions, medication-assisted treatments, collateral services, case management, crisis intervention, Treatment Planning, recovery support services, and discharge services.

As patients transition between levels of service, progress in all six (6) dimensions should be formally assessed at regular intervals, in accordance with the patient's severity level and functional impairment, as clinically indicated. These assessments help to ensure that patients are placed in the appropriate level of care based on medical necessity, as reviewed and verified by a LPHA. Level of care transitions need to be based on clinical need, as opposed to funding source or provider preferences.

Continuity of care and longitudinal follow up are critical for SUD patients. Referrals and linkages to different service and levels of care within the SUD, physical, and mental health systems help to ensure that patient needs are appropriately addressed. High quality care is characterized by the seamless linking of different levels of care, both within the SUD system of care and between other systems of health care. This streamlined system of care can be achieved by case management, role induction (preparing individuals for treatment by sharing the rationale of treatment, treatment process, and their role in that process), warm hand-offs, and assertive outreach.

Providers must also familiarize themselves with other requirements that govern SUD treatment. These include the California Code of Regulations Title 22, Title 9, Alcohol and/or Other Drug Program Certification Standards, and the provisions of the System Transformation to Advance Recovery and Treatment, Organized Delivery System (START-ODS) including SAPC Bulletins, and the Contract's Specific Services to be Provided and Definitions of Services.

A brief description of funded services and levels of care are outlined below, however, a detailed description of ASAM levels of care is beyond the scope of this document. Providers need to refer to *The ASAM Criteria* textbook or other resources for additional information.

Case Management

Case Management is a collaborative and coordinated approach to the delivery of health and social services that links patients with appropriate services to address specific needs and achieve treatment goals. Case Management is a patient-centered service that is intended to complement clinical services, such as individual and group counseling, to address areas in an individual's life that may negatively impact treatment success and overall quality of life. Case Management offers support services to patients to increase self-efficacy, self-advocacy, basic life skills, coping strategies, self-management of biopsychosocial needs, benefits and resources, and reintegration into the community.

Guiding principles¹ for Case Management are the following:

- Case Management is patient-centered and should be primarily focused on meeting the varied needs of patients;
- Case Management provides a point of contact between health and social services;
- Case Management provides advocacy by acting in the patient's best interests;
- Case Management helps patients navigate and obtain community resources, and integrate into the community after discharge from inpatient or residential services;
- Case Management is culturally sensitive;
- Case Management must be flexible; and
- Case Management is anticipatory and understands that SUDs may be chronic and relapsing.

Case Management is available to all patients who enter the SUD treatment system. This service is available throughout the treatment episode and may be continued during Recovery Support Services. Case Management services may be provided face-to-face or by telephone, with the patient.

Description of Case Management and Services

The primary goal of Case Management is to ensure patients in SUD treatment receive the necessary support and services available to be successful in meeting treatment and recovery goals. Since patients in SUD treatment have an array of service needs and interact with multiple systems, one barrier to successfully completing treatment may be a lack of communication and established referral procedures between health and social systems. Case Management is effective at keeping individuals engaged in treatment and moving toward recovery by addressing other problems concurrently with substance use.² Case Management services are especially important for patients with chronic health problems, co-occurring disorders, those experiencing homelessness or who are involved with the criminal justice system.

To successfully link patients to services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate resources, both at the system and the service levels, to refer patients to relevant networks of support. Services provided through Case Management are thus tailored to facilitate continuity of care across all systems of care and provide extensive assessment and documentation of patient progress toward self-management and autonomy.

Although an important component of Case Management in SUD treatment is connecting patients to outside systems of care, such as physical and mental health systems, Case Management is equally important in transitioning patients through the SUD system of care. Comprehensive SUD treatment often requires that patients move to different levels of care within the SUD continuum, and case managers help to facilitate those transitions.

There are three (3) core Case Management functions that providers should perform to ensure successful treatment outcomes and recovery: **Connection, Coordination, and Communication**. Although not an exhaustive list, please see **Table 8** for a list of the three (3)

¹ SAMHSA (US); 2000. (Treatment Improvement Protocol (TIP) Series, No. 27.) Chapter 2 – Applying Case Management to Substance Abuse Treatment.

² SAMHSA (US); 2000. (Treatment Improvement Protocol (TIP) Series, No. 27.) Chapter 4 – Evaluation and Quality Assurance of Case Management Services.

functions and the respective activities that can be performed and billed under Case Management.

- **Connection:** Establishing connections through referrals that link patients to housing, educational, social, prevocational, vocational, rehabilitative, or other community services. This includes providing high-quality referrals and linkages for patients to necessary resources and services as identified in the Treatment Plan, which includes Case Management needs. High-quality referrals and linkages require the case manager to play an active role to reduce access barriers and ensure patients have ‘actual’ access to needed services. This means going beyond the distribution of resource lists to patients, and actively establishing relationships and protocols with external providers to ensure patients will be connected with agencies—and served upon referral.

In addition, case managers must assist patients with applying for and maintaining health and public benefits (e.g., Medi-Cal, My Health LA, General Relief and Los Angeles County (County) funded programs/projects). This includes helping patients who have moved and must transfer their Medi-Cal benefits from their previous county of residence to Los Angeles County.

- **Coordination:** Care coordination is intended to address fragmentation of care, and help patients better navigate and access treatment across the different systems of care. Case managers perform care coordination by acting as a bridge between health and human service providers to ensure that information is appropriately exchanged, and patients are successfully linked to needed resources/services. Activities include helping patients set up medical appointments, ensuring that SUD providers at the treating agency are aware of services being conducted by other health providers, and following up with patients in service transition or notable events. For example, case managers should follow up with patients within a few days of an emergency room visit, hospital discharge, or discharge from a residential facility. As SUD patients interact with multiple systems, it is the responsibility of case managers to help improve the accessibility of services for the patient by reducing barriers between care delivery settings.

Additionally, case managers should coordinate successful transitions between SUD levels of care, including setting up an assessment appointment, transferring necessary documentation to the receiving treatment agency, and providing a warm hand-off for necessary services. If patients are transitioned to a higher or lower level of care at a different treatment agency, the case manager should use the SBAT to identify providers that meet the individualized needs of the patient. Case managers are expected to schedule appointments and monitor referrals until obtaining confirmation that patients have been enrolled at the receiving treatment agency.

- **Communication: Communication is the primary way in which care coordination activities are successfully performed.** Patients in the SUD system of care receive services from various service providers, and it is the responsibility of case managers to be a line of communication between patients and others. Communication may include telephone, emails, letters, and progress notes and/or reports to the County, State, and other service providers on behalf of the patient. For example, a patient may need a letter sent to a judge verifying that they are participating in SUD treatment. At times, case managers must also advocate on behalf of patients. If patients’ service needs are not being met, case

managers will educate patients on their rights and advocate for patients with their service providers

Table 8. Core Functions of Case Management

<u>The 3 C's of Case Management</u>	
<p>1. <u>CONNECTION</u>: Referrals that link patients to housing, educational, social, prevocational, vocational, rehabilitative, or other community services</p> <ul style="list-style-type: none"> • Establishing & Maintaining Benefits <ul style="list-style-type: none"> ○ Helping patients to apply for, and maintain health and public benefits (e.g., Medi-Cal, My Health LA, General Relief, Perinatal, Housing, etc.). ○ Conducting the Coordinated Entry System (CES) Survey Packet including: Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) for adults; or the Next Step Tool for youth. ○ Transferring benefits from the previous county of residence to Los Angeles County for patients who have moved. • Community Resources <ul style="list-style-type: none"> ○ Linking patients to community resources and services that can maximize independence and support recovery goals, including: referrals to local food banks and/or community churches for groceries and meals; clothing assistance; transportation services; vocational services; support for employment; and education. 	
<p>2. <u>COORDINATION</u>: Acting as a liaison to aid transitions of care and arranging for health services and social services.</p> <ul style="list-style-type: none"> • Transitioning between SUD Levels of Care <ul style="list-style-type: none"> ○ Facilitating necessary transitions in SUD levels of care (e.g., from residential to intensive outpatient treatment, outpatient to Recovery Support Services, etc.), including initiating referrals to the next level of care, and coordinating with and forwarding necessary documentation to the accepting treatment agency. • Health Services <ul style="list-style-type: none"> ○ Coordinating care with physical health (including managed care health plans such as L.A. Care and Health Net), community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery. • Social Services <ul style="list-style-type: none"> ○ Coordinating with state and County entities (DPSS, DCFS, Probation, Superior Courts, Housing Providers, etc.) to ensure the social aspects of health and well-being are being coordinated with health services. 	
<p>3. <u>COMMUNICATION</u>: Correspondence, including emails, letters, and reporting documentation, by the case manager to the County, state, and other service providers on behalf of the patient.</p> <ul style="list-style-type: none"> • Health Providers <ul style="list-style-type: none"> ○ Communicating with physical health (including managed care health plans such as L.A. Care and Health Net), community health clinics and providers, and mental 	

health providers to ensure a coordinated approach to whole person health service delivery.

- Monitoring and following up with other agencies regarding scheduled services and/or services received by patients.
- **Service Partners**
 - Communicating with Department of Public Social Services (DPSS) workers, Department of Children and Family Services (DCFS) social workers, Department of Mental Health (DMH) workers, Los Angeles Superior Court, Probation Officers, Housing Providers, etc., to align objectives and activities.
- **Advocacy**
 - Advocating for patients with health/social service providers, County and community partners, and others (such as officials at schools, juvenile or adult court hearings and/or meetings with corrections staff, and Student Attendance Review Boards or other school-related hearings) in the best interests of patients (e.g., respectfully advocating for necessary services to be provided in a timely manner).

Case Management Considerations for People in Vulnerable Groups

People with special needs require more intensive Case Management activities. Moreover, County agencies (DCFS, DPSS, Law Enforcement, Los Angeles Superior Court, etc.) may require providers to submit additional documentation and perform additional activities (e.g. attending court hearings or meeting with case workers to advocate on the patient's behalf).

These groups include people with HIV/AIDS, mental illnesses, homelessness, perinatal women, adolescents, and the criminal justice-involved. Each population will require coordination activities to help an individual effectively navigate, access, and participate in an appropriate SUD level of care, access health and mental health services, secure housing, and obtain other supportive services.

Patients Experiencing Homelessness

Housing and an individual's living environment are oftentimes a critical component of the ability to achieve and maintain recovery from SUDs. Therefore, case managers should identify patients in need of housing assistance and perform connection and coordination activities according to available resources. For providers that are trained and have the capacity to deliver housing services, billable Case Management services include the following:

- **Completing the Coordinated Entry System (CES) Survey Packet**, including the **Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)** for adults, and the **Next Step Tool** for youth.
- Entering and updating patient information in **HMIS**.
- Connecting patients to CES agencies for adults, youth and families
- Coordinating housing activities with CES Housing Navigators, such as gathering necessary documents, completing housing applications, choosing potential housing sites, applying for move-in resources and re-integration into the community.

See ***the Homeless Services*** section for more information.

Criminal Justice-Involved Patients

Case managers should communicate with criminal justice staff (i.e., Probation, Sheriff,

Los Angeles Superior Courts, etc.) to ensure that Case Management activities meet criminal justice supervision requirements. As needed, case managers may be asked to perform the following activities:

- Attend court hearings to report progress in treatment.
- Arrange letters, phone calls, and/or direct face-to-face meetings with law enforcement agencies (Probation Department, Sheriff's Department, and Parole) and courts (Superior Courts) about patients.
- Enter data into non-Sage electronic systems (e.g., Treatment Court Probation eXChange (TCPX) and Drug Court Management Information System (DCMIS), Probation Department web-based reporting system).

See ***Los Angeles County Superior Court Referrals*** and ***Los Angeles County Sheriff's Referrals*** sections for more information.

Children and Family Services

For patients that participate in County funded programs for children and family services, one of the primary focuses for providers should be the family unit (e.g., helping patients meet requirements set forth in their family reunification plan). Therefore, Case Management activities should help patients gain access to services and resources that take into account family needs. Case Management activities for this group may include linkage to parenting classes, child care, food and clothing assistance, and family planning services.

When working with children, families, and perinatal women, the case manager should confer with the patient's DPSS worker, DCFS social worker, DMH worker, etc., at least once to ensure that the objectives and activities developed in Case Management are consistent and don't unintentionally overwhelm the patient.

See the ***Department of Public Social Services (DPSS) – California Work Opportunity and Responsibility to Kids (CalWORKs) Referrals***, ***Department of Children and Family Services (DCFS) – Promoting Safe and Stable Families Time-Limited Family Reunification (PSSF-TLFR)***, ***Department of Children and Family Services – Family Dependency Drug Court (FDDC)***, and ***Pregnant and Parenting Women*** sections to learn more about these populations and requirements.

Service Requirements and Components

Eligibility Criteria for Case Management Services

Case Management services are available to all patients who are enrolled in all levels of care under the Drug Medi-Cal Organized Delivery System (DMC-ODS). Reimbursement eligibility criteria for Case Management services are the same as DMC-ODS enrollment criteria. The beneficiary must:

- Have Los Angeles as their County of Residence and be treated at a SAPC-contracted treatment facility; Be eligible for Medi-Cal or My Health LA, or concurrently participating in other County funded programs/projects such as AB 109, CalWORKs, GR, JJCPA, PSSF-TLFR, or Title IV-E;
- Meet medical necessity criteria based upon ASAM criteria or be determined to be at-risk for developing SUD for ages 12 to 20, if applicable; and
- Be enrolled in a treatment level of care or recovery support services

Staffing Requirement

Various members of the treatment team can function as the case manager, including registered/certified SUD counselors and Licensed Practitioners of the Healing Arts.

Documentation

Planning and documentation are important to a structured and integrated Case Management model. Following the comprehensive and multidimensional ASAM Continuum or SAPC Youth ASAM assessment, which should include a patient's Case Management needs, a case manager must discuss the results and collaborate with the patient to develop a plan that includes the patient's Case Management needs. The plan for how to address a patient's Case Management needs should be incorporated into the Treatment Plan.

The Case Management component of the Treatment Plan must be able to track key components of service, including Case Management needs, Connection/Coordination/Communication activities, and advocacy efforts. Regular Miscellaneous Notes clearly documenting Case Management activities are critical to demonstrating the rationale and details of the activities performed. Case managers are responsible for working with patients to implement the Case Management component of the Treatment Plan and monitor the patient's progress.

The Case Management component of the Treatment Plan must describe the patient's relevant resources and prioritized service needs and must include a quantifiable statement of the patient's short-term and long-term goals, planned activities, desired outcomes, and target completion dates. When appropriate, the Treatment Plan must identify barriers, contingencies for anticipated complications, or alternative plans to achieve stated objectives on which the case manager should focus.

Although evaluating for Case Management needs, discussing the Case Management component of the Treatment Plan, and carrying out Case Management activities as outlined in the Treatment Plan can be billed under Case Management, Treatment Plan development and updates are not a part of Case Management and should only be billed under Treatment Plan.

Service Hour Requirements

Up to ten (10) hours of Case Management services per month, per level of care, may be provided for all patients served in the County specialty SUD system (adults, young adults, and youth) except for Outpatient At-Risk and Recovery Support Services.

Case Management service hours for At-Risk youth and young adults are combined with other treatment services (Group Counseling, Patient Education, and Individual Counseling) and cannot exceed 40 units or ten (10) hours per 60-days (inclusive of intake services). Patients are allowed up to two (2) episodes per calendar year.

Case Management service hours for Recovery Support Services are also combined with other treatment services (Individual Counseling, Group Counseling, Recovery Monitoring, and Substance Abuse Assistance). Combined services cannot exceed six (6) hours per month for youth (age 12-17), and seven (7) hours per month for adults (age 18+).

Case Management services shall be consistent with and shall not violate confidentiality of patients as set forth in 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient

Records; CFR 438 Managed Care; HIPAA; California Code of Regulations (CCR) Title 9 Counselor Certification the California Code of Regulations; and CCR Title 22 Drug Medi-Cal.

Outpatient for At-Risk Youth and Young Adults (ASAM 1.0 AR)

ASAM 1.0-AR treatment services are appropriate for youth (ages 12-17) and young adults (ages 18-20) who do not meet DSM criteria for a SUD, but who would benefit from services to reduce or cease substance use and prevent progression into a DSM diagnosis.

Service Hour Requirements

Treatment services at this level of care include intake services (e.g., screening, intake, assessment and Treatment Planning), group counseling, patient education, individual counseling, family therapy and case management

A maximum of two (2) treatment episodes can be provided **per calendar year** including:

- Treatment services for a maximum of 40 units or ten (10) hours per 60 days, *inclusive of intake services*. See **Table 6** above for recommended durations for allowable services.

Outpatient Treatment (ASAM 1.0)

ASAM 1.0 treatment services are those alcohol and drug treatment services which are provided in an environment that facilitates recovery, directed towards alleviating and/or preventing alcohol and drug problems. ASAM 1.0 treatment services do not require residency at an agency's facility as part of the treatment and recovery process.

This level of care is appropriate for patients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.

Service Hour Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), alcohol/drug testing, discharge services, and case management.

At least two (2) hours of Treatment Services must be provided per month, and up to:

- Six (6) hours per week for youth (ages 12 – 17)
- Nine (9) hours per week for young adults (ages 18 – 20) and adults (ages 21+).

Intensive Outpatient Treatment (ASAM 2.1)

ASAM 2.1 treatment services are appropriate for patients with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions. It is appropriate for patients who need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting.

Service Hour Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), alcohol/drug testing, discharge services, and case management.

Treatment services must be provided between:

- Six (6) and 19 hours per week for youth (ages 12 – 17)
- Nine (9) and 19 hours per week for young adults (ages 18 – 20) and adults (ages 21+)
- Six (6) and 30 hours per week for Perinatal youth (ages 12-17)
- Nine (9) and 30 hours per week for Perinatal young adults (ages 18-20) and adults (ages 21+)

If the minimum hours of service are not met, reimbursement will be reduced to the ASAM 1.0 fee/rate. If minimum service units are not met for four (4) or more weeks, the patient needs to be stepped down to a lower level of care and further reimbursement will be disallowed.

Residential Services

Low Intensity Residential (ASAM 3.1)

ASAM 3.1 residential services are 24-hour non-medical, short-term rehabilitation services for patients with a SUD diagnosis. It is appropriate for patients who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment.

Incidental Medical Services (IMS) are those services provided at a licensed residential facility by a health care practitioner, or staff under the supervision of a health care practitioner, to address medical issues associated with detoxification, treatment, or recovery services. IMS does not include general primary medical care or medical services required to be performed in a licensed health facility, as defined by HSC Section 1200 or 1250.

Importantly, Incidental Medical Services may be approved by the State to allow for Medications for Addiction Treatment (MAT) and incidental medical services, including withdrawal management, to be provided in residential settings.

Service Hour Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), non-emergency transportation, alcohol/drug testing, discharge services, case management, and room and board.

Clients enrolled in Medi-Cal or My Health LA cannot be charged fees for room and board and/or treatment services. However, SAPC is reviewing DPSS' policy on the transfer of General Relief (GR) and/or CalFresh benefits to a residential provider and will make a final determination soon on whether to grant an exception. While this policy is under review, SAPC providers may

continue to collect GR/CalFresh benefits from residential clients and those fees must be reported to SAPC on the year-end cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

At least **one 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, Treatment Plan, Discharge Services, and Case Management), or **four to six 15-minute units** for group-based services (Group Counseling and Patient Education) per patient per day. Treatment services must be provided **at least 20 hours per week** and include preparation for step down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services must equal at least half of the weekly treatment hour standard (10 hours or 40 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services (**up to 2 hours weekly** for both on-site and off-site services). Please see the Residential Treatment Program bulletin for a more detailed list of approved services. If less than 10 hours or 40 units of services are provided per week, for more than two (ages 12-20) or three (ages 21+) weeks, the patient needs to be stepped down to a lower level of care and further reimbursement will be disallowed. When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in the progress notes.

Providers may choose to hold a patient's bed if the patient is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held will only be reimbursed for room and board and will not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs.

Residential services must be preauthorized by SAPC and patients must meet medical necessity requirements. See **Table 17** for Residential Pre-authorization and Reauthorization Service Limits for more details.

High Intensity Residential – Population Specific (ASAM 3.3)

ASAM 3.3 residential services are 24-hour non-medical short-term rehabilitation services for patients with a SUD diagnosis. It is appropriate for patients with functional limitations that are primarily cognitive, who require a slower pace to treatment, and are unable to fully participate in the social and therapeutic environment. These functional limitations may be either temporary or permanent, and may result in problems in interpersonal relationships, emotional coping skills, or comprehension.

Importantly, Incidental Medical Services may be approved by the State to allow for Medications for Addiction Treatment (MAT) and incidental medical services, including withdrawal management, to be provided in residential settings.

Level 3.3 services are only available to youth on a case-by-case basis, per medical necessity.

Service Hour Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including referral to MAT for alcohol and

opioid abusers unless patient refusal is documented in progress notes), non-emergency transportation, alcohol/drug testing, discharge services, case management, and room and board.

Clients enrolled in Medi-Cal or My Health LA cannot be charged fees for room and board and/or treatment services. However, SAPC is reviewing DPSS' policy on the transfer of General Relief and/or CalFresh benefits to a residential provider and will make a final determination soon on whether to grant an exception. While this policy is under review, SAPC providers may continue to collect GR/CalFresh benefits from residential clients and those fees must be reported to SAPC on the yearend cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

At least **one 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, Treatment Plan, Discharge Services, and Case Management), or **four to six 15-minute units** for group-based services (Group Counseling and Patient Education) per patient per day. Treatment services must be provided **at least 24 hours per week** and include preparation for step down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services must equal at least half of the weekly treatment hour standard (12 hours or 48 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services (**up to 2 hours weekly** for both on-site and off-site services). Please see the Residential Treatment Program bulletin for a more detailed list of approved services. If less than 12 hours or 48 units of service are provided per week, for more than two (ages 12-20) or three (ages 21+) weeks, the patient needs to be stepped down to a lower level of care and further reimbursement will be disallowed. When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in the progress notes.

Providers may choose to hold a patient's bed if the patient is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held will only be reimbursed for room and board and will not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs.

Residential services must be preauthorized by SAPC and patients must meet medical necessity requirements. See **Table 17** for Residential Pre-authorization and Reauthorization Service Limits for more details.

High Intensity Residential – Non-Population Specific (ASAM 3.5)

ASAM 3.5 residential services are 24-hour non-medical short-term rehabilitation services for patients with a SUD diagnosis. It is appropriate for patients who have specific functional limitations and need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances.

Importantly, Incidental Medical Services may be approved by the State to allow for Medications for Addiction Treatment (MAT) and incidental medical services, including withdrawal management, to be provided in residential settings.

Service Hour Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), non-emergency transportation, alcohol/drug testing, discharge services, case management, and room and board.

Clients enrolled in Medi-Cal or My Health LA cannot be charged fees for room and board and/or treatment services. However, SAPC is reviewing DPSS' policy on the transfer of General Relief and/or CalFresh benefits to a residential provider and will make a final determination soon on whether to grant an exception. While this policy is under review, SAPC providers may continue to collect GR/CalFresh benefits from residential clients and those fees must be reported to SAPC on the yearend cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

At least **one 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, Treatment Plan, Discharge Services, and Case Management), or **four to six 15-minute units** for group-based services (Group Counseling and Patient Education) per patient per day. Treatment services must be provided **at least 22 hours per week** and include preparation for step down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services must equal at least half of the weekly treatment hour standard (11 hours or 44 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services (**up to 2 hours weekly** for both on-site and off-site services). Please see the Residential Treatment Program bulletin for a more detailed list of approved services. If less than 11 hours or 44 units of service are provided per week, for more than two (ages 12-20) or three (ages 21+) weeks, the patient needs to be stepped down to a lower level of care and further reimbursement will be disallowed. When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in the progress notes.

Providers may choose to hold a patient's bed if the patient is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held will only be reimbursed for room and board and will not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs.

Residential services must be preauthorized by SAPC and patients must meet medical necessity requirements. See **Table 17** for Residential Pre-authorization and Reauthorization Service Limits for more details.

Withdrawal Management

Withdrawal management (WM), also known as detoxification, is a set of treatment interventions aimed at managing acute intoxication and withdrawal from alcohol and other substances. The rationale for WM is to provide the appropriate level of support to allow for patient safety during

the withdrawal period, which then allows the patient and treatment team to work together to determine the optimal ongoing treatment strategy.

While WM may be an opportunity to initiate lasting abstinence from alcohol and/or other drugs, the primary goal is patient safety to minimize the health risks associated with withdrawal, not long-term abstinence. As such, WM should not be withheld from patient due to provider uncertainty about their commitment to long-term abstinence.

WM is a critical point within the ASAM continuum of care. All SUD patients, particularly those with alcohol and opioid use disorders, should be considered for WM and have access to these essential treatment services. However, in and of itself, WM does not constitute adequate treatment for addiction. Effective WM will increase the likelihood that a patient will complete withdrawal successfully to transition to the next stage in the addiction treatment process. Patients who receive WM should be connected with ongoing treatment services.

The science of comprehensive and effective SUD treatment supports the use of medications for WM and the use of medications in addiction treatment. The fact that individuals have recovered from SUDs previously without the aid of WM services or medication-assisted treatment (MAT) does not imply that these services are unnecessary. It is crucial that addiction treatment evolves with the science that guides treatment. Research has consistently demonstrated that the use of medications, both in the form of WM and maintenance treatment with MAT, help to improve treatment engagement and SUD outcomes, particularly when combined with evidence-based psychosocial interventions. For this reason, the passive or active discouragement of the use of medications for WM and FDA-approved MAT is contrary to the science of addiction treatment, and WM and MAT must be discussed as a treatment option for all patients for whom it may be appropriate and helpful.

Table 9.

Level of Care	ASAM Level	Description
Ambulatory (Outpatient) Withdrawal Management without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.
Clinically Managed Residential Withdrawal Management	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.
Medically Monitored Inpatient Withdrawal Management	3.7-WM	Severe withdrawal; needs 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring.
Medically Managed Intensive Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and physician visits to modify withdrawal management regimen and manage medical instability.

Withdrawal Management for Youth (ages 12 – 17)

Withdrawal management is generally not indicated for youth because they typically have not consumed substances for sufficient duration, intensity, or frequency to elicit significant withdrawal symptoms. However, instances where WM for youth under age 18 is clinically indicated will be authorized by SAPC on a case-by-case basis.

Withdrawal management should consist of three (3) essential features:

1. Assessment of needs
2. Stabilization
3. Facilitation of follow up, including readiness for and entry into SUD treatment

Assessment

1. Assessment of WM needs must occur during every initial SUD assessment when a patient shows up for treatment. This assessment needs to be performed by appropriate personnel operating within their scope of practice and licensure and include a determination of anticipated risks confronting patients that will inform the need for WM, the intensity of services needed, and the most appropriate treatment setting.
2. Patients must be assessed using a full SAPC Youth ASAM assessment, which should result in a determination about if WM services are necessary. If additional clinical assessment information is needed for Dimension 1 (withdrawal potential), additional validated withdrawal assessment tools such as the Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opioid Withdrawal Scale (COWS) may be used to provide additional assessment information.
3. If assessment indicates WM is needed, qualified SUD treatment providers must make a clinical determination of the most appropriate level of care (ambulatory WM vs. residential WM vs. inpatient WM) and explain the WM options, including medication, available to the patient.
4. Individuals recommended for WM in ambulatory (aka: outpatient) settings should be at lower risk for complications and have a greater likelihood of successful WM than individuals recommended for withdrawal services in residential or inpatient settings. Assessments need to also take into consideration the unique situations of the individual, the severity of the presenting symptoms, as well as patient preference.
5. In the event the patient is assessed as needing a level of care other than the one provided at the current location, SUD treatment providers have two options: 1) Call the Substance Abuse Service Helpline (SASH) to schedule an intake appointment with another agency, or 2) Identify and call another agency directly by using the SBAT to set up an intake appointment. SUD treatment providers must make every effort to facilitate a warm hand-off with the receiving treatment agency. The new intake appointment must be re-scheduled within three (3) business days. If the agency does not use the County's EHR, Sage, the assessment results must be sent to the receiving treatment agency either electronically or via fax within 24 hours.

Stabilization

Following a comprehensive assessment of WM needs, the focus of the stabilization period is on developing a Treatment Plan to effectively manage the withdrawal symptoms of the patient, while also considering the potential general medical and psychiatric complications that may accompany withdrawal.

1. The SUD counselor must work with the patient to develop a comprehensive Treatment Plan that takes into account the biopsychosocial needs of an individual to effectively manage withdrawal symptoms, which may include the use of medications.
2. Stabilization should, when appropriate, consist of a combination of psychosocial interventions and medications.
3. Once it is determined that a patient would benefit from and is interested in MAT, a determination needs to be made about whether the most appropriate intervention is acute management of the withdrawal symptoms either with or without medications, or

induction onto agonist (methadone), partial agonist (buprenorphine), or antagonist (naltrexone) maintenance therapy. Assessing this determination early is paramount given that it impacts the interventions used during an individual's care in WM settings. When WM medications are indicated, an evidence-supported approach should be used to select the pharmacological agent, dosage, and route of administration.

4. Although not all individuals will be in a state of mind to effectively engage in behavioral/talk therapy during WM, psychosocial interventions are an important component of the services that should be offered in the withdrawal management setting. Motivational interviewing, for example, can be skillfully employed during WM to better understand patients' readiness to change and help them progress along the readiness continuum to encourage them to continue with treatment after their withdrawal symptoms are addressed.
5. Throughout WM, qualified staff must continually assess the patient for changes in their condition and health status.
6. The treatment agency must assign a case manager to the patient to assist them with the transition process to treatment.

Facilitation of Follow-Up

In and of itself, WM does not constitute adequate addiction treatment and thus patients who receive withdrawal services should be connected with ongoing SUD treatment.

1. As early during the withdrawal process as is feasible and appropriate, SUD providers must engage their patients in discussions about their readiness for change and begin preparing them for entry into ongoing SUD treatment at the next point along the continuum of SUD care. Case management can and should support this level of care transition.
2. This preparation must include engaging the patient in discussion regarding comprehensive SUD treatment and the fact that WM is typically only the first component of treatment, and care coordination priorities and activities described in the section above titled *Coordination of Transitions in Care*.
3. The duration of WM services must be based on individual patient need as determined by qualified personnel operating within their scope of practice and licensure.

Ambulatory Withdrawal Management

Ambulatory Withdrawal Management Without Extended Monitoring (ASAM 1-WM)

ASAM 1-WM ambulatory services are provided in outpatient settings for patients with mild to moderate withdrawal symptoms. Patients treated in this setting should require no more than daily or less than daily outpatient supervision and are generally likely to complete withdrawal management and to continue treatment or recovery.

Individuals treated in this setting should be physically and psychiatrically stable enough to be managed in an outpatient setting. Patients should be at lower risk for withdrawal complications and have a greater likelihood of successful WM than individuals recommended for withdrawal services in residential (ASAM 3.2-WM) or inpatient (ASAM 3.7-WM and 4-WM) settings.

ASAM 1-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower level of care, as clinically indicated.

Service Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, ambulatory detoxification, medication services (including referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), alcohol/drug testing, discharge services, and case management.

Residential Withdrawal Management (ASAM 3.2-WM)

ASAM 3.2-WM services are 24-hour short-term rehabilitation services provided in residential settings for patients with moderate withdrawal and who need 24-hour support to successfully complete withdrawal management. Importantly, Incidental Medical Services may be approved by the State to allow for Medications for Addiction Treatment (MAT) and incidental medical services, including withdrawal management, to be provided in residential settings.

Patients appropriately treated in residential WM settings typically exhibit, have a history of exhibiting, or are at risk for exhibiting moderate withdrawal symptoms with a greater need for support than can be provided in ambulatory WM settings, but less need for medical supervision and support than is provided in inpatient WM settings.

The care provided at level 3.2-WM is delivered by interdisciplinary staff that are appropriately trained and credentialed to assess the patient and manage moderate withdrawal. Although it is not a requirement that a physician be on-site at all times, it is recommended that a licensed physician with specific training in addiction medicine or addiction psychiatry be available for consultation as medically necessary (for example, if a physician prescribes and orders a WM taper, the nurse onsite can carry out the order, without the physician needing to be onsite). Individuals in 3.2-WM should receive pharmacotherapy integrated with psychosocial therapies. There also must be coordination of necessary services and/or referral to other levels of care (as needed) through direct affiliation or external referral process.

Note: To participate in 3.2-WM, providers are not required to provide MAT services on-site. Providers may partner and refer patients to off-site physicians for MAT services. ASAM 3.2-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower level of care, as clinically indicated.

Service Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), non-emergency transportation, alcohol/drug testing, discharge services, case management, and room and board (which cannot include financial participation by the patient in the form of payment/transfer of federal, state or local benefits such as Cal Fresh).

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs.

Inpatient Withdrawal Management – Medically Monitored (ASAM 3.7-WM)

ASAM 3.7-WM services are short-term medically monitored settings for patients with severe

withdrawal that offers 24-hour nursing care and physician visits, as necessary. Patients treated in this setting are unlikely to complete WM without medical monitoring and have severe problems in Dimensions 1, 2, or 3 that require hospital-level care with medical oversight. Treatment in inpatient WM settings should be reserved for those who cannot be successfully managed at a lower level of WM care.

ASAM 3.7-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower level of care, as clinically indicated.

Transitions to and from this level of care are critical and must be managed carefully, with the plan to transition to an appropriate lower level of SUD care, when clinically indicated.

Within the specialty SUD system, ASAM level 3.7-WM includes Chemical Dependency Recovery Hospitals and Free Standing Psychiatric Hospitals. ASAM level 3.7-WM may also be provided in general acute hospitals, in which case the services are funded through fee-for-service (FFS) Medi-Cal for physical health systems.

Service Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), non-emergency transportation, alcohol/drug testing, discharge services, case management, and room and board (which cannot include financial participation by the patient in the form of payment/transfer of federal, state or local benefits such as Cal Fresh).

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs.

Inpatient Withdrawal Management – Medically Managed (ASAM 4.0-WM)

ASAM 4.0-WM services are short-term medically managed settings for patients with severe and unstable withdrawal that offers 24-hour nursing care and daily physician visits. Patient treated in this setting are unlikely to complete WM without medical management and have severe problems in Dimensions 1, 2, or 3 that require hospital-level care with medical oversight. Treatment in inpatient WM settings should be reserved for those who cannot be successfully managed at a lower level of WM care.

ASAM 4-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower level of care, as clinically indicated.

Transitions to and from this level of care are critical and must be managed carefully, with the plan to transition to an appropriate lower level of SUD care, when clinically indicated.

Within the specialty SUD system, ASAM level 4-WM is provided in Chemical Dependency Recovery Hospitals and Free Standing Psychiatric Hospitals. ASAM level 4-WM may also be provided in general acute hospitals, in which case the services are funded through FFS Medi-Cal for physical health systems.

Service Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), non-emergency transportation, alcohol/drug testing, discharge services, case management, and room and board (which cannot include financial participation by the patient in the form of payment/transfer of federal, state or local benefits such as Cal Fresh).

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs.

Opioid Treatment Programs (1-OTP)

Opioid Treatment Programs (OTPs) are treatment settings that provide MAT, including methadone, buprenorphine, naloxone (for opioid overdose prevention), and disulfiram for individuals with opioid and alcohol use disorders. OTPs may also offer other types of MAT to address co-morbid SUD in addition to opioid use disorder. A distinguishing feature of OTPs compared to other SUD levels of care is that OTPs are the *only* setting that can legally provide methadone treatment for addiction. OTPs also offer a broad range of other services including medical, perinatal and/or other, psychosocial services.

An OTP is identified as an ASAM level of care and as such, medical necessity for OTP services must be established, including a DSM-5 diagnosis of a SUD and an appropriate level of care designation via an ASAM assessment.

Clinicians, such as counselors and non-prescriber LPHAs play an important role in identifying who may benefit from MAT and treatment at an OTP. For example, non-prescriber SUD service providers should explain potential MAT benefits alongside other services and refer patients to appropriate health professionals for further assessment. SUD providers from across disciplines will need to work together to ensure familiarity with, and access to, MAT both in OTP and other SUD treatment settings.

Service Requirements

Treatment services at this level of care include screening, assessment/intake, Treatment Planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including prescribing methadone, naltrexone, buprenorphine and naloxone as needed), alcohol/drug testing, syphilis testing, tuberculosis testing, discharge services, and case management/care coordination.

Patients served in OTP settings must receive between 50 and 200 minutes of treatment services per calendar month. Additional services may be provided based on medical necessity.

Opioid Treatment Programs are regulated under California Code of Regulations Title 9: Rehabilitative and Developmental Services.

Documentation

All OTP providers must have a complete initial ASAM Assessment for all patients. Reimbursement for cases in which ASAM assessments were not completed by this date will be subject to recoupment.

Consistent with Title 9 requirements, OTP providers must re-verify DMC eligibility and perform justification every 12 months from treatment admission date, for patients who need ongoing OTP care. An annual ASAM assessment is not required. To re-establish medical necessity, a narrative justification of the ongoing need for OTP services is sufficient.

Recovery Support Services

Recovery Support Services (RSS) are aftercare support services designed to help individuals become and stay engaged in the recovery process and reduce the likelihood of relapse.³ RSS emphasizes the patients' central role in managing their health and recovery and promotes the use of effective self-management and coping strategies, as well as internal and community resources to support ongoing self-management. Medical necessity is considered established for any individual transitioning directly into RSS from treatment. If there is a lapse between treatment discharge and receipt of RSS, or RSS is discontinued, a screening needs to occur to determine if RSS is still the appropriate service level.

RSS is available for youth (ages 12 – 17), young adult (ages 18 – 20), and adult (age 21+) patients who have completed treatment or left treatment with satisfactory progress and are in recovery. This applies to patients discharging from any level of care, provided they are not concurrently enrolled in treatment services. The last treatment provider of care will serve as the default provider of RSS, unless necessary services are not offered, or the patient prefers a change in provider. These services can be delivered by either an experienced registered or certified SUD counselor or LPHA and will be offered when they are deemed medically necessary by an LPHA (e.g., after completion of a treatment episode).

RSS must be conducted face-to-face in a contracted DMC-certified treatment facility or at an approved field-based services location, and/or by telephone, with the call being made from a DMC-certified facility.

RSS may include participation in group meetings and/or individual counseling to assist patients in meeting the goals contained in their RSS plans.

Individuals who are released from custody, or those who will soon be released from custody and have completed treatment while incarcerated, are eligible for RSS. While in custody, ideally the patient's SUD counselor should refer the patient into RSS prior to release from incarceration. Placement in RSS will be facilitated by co-located CENS staff.

Medical necessity for RSS aligns with the DMC eligibility period (6 months for non-OTP treatment and 12 months for OTP treatment). All patients transitioning directly from any SUD treatment to RSS already meet medical necessity based on their DMC eligibility. Therefore, a new screening or ASAM Continuum or SAPC Youth ASAM assessment is not required upon admission. To enroll a patient in RSS services, a new CalOMS/LACPRS admission and Financial Eligibility form are needed. Continued RSS participation is based on continued DMC eligibility.

³ <http://store.samhsa.gov/product/What-Are-Peer-Recovery-Support-Services-/SMA09-4454>

Participation in RSS is voluntary for the patient. Therefore, treatment providers should make every effort to educate and engage patients in, and facilitate acceptance of RSS, while ultimately deferring to the patient's choice and preferences.

Accessing Recovery Support Services

During SUD Treatment

Given the value of RSS, the patient's treatment provider should explain the benefits of RSS at the beginning of treatment, during treatment, and as treatment is concluding. Treatment providers should introduce the patient to the RSS counselor/clinician and ensure that a warm hand-off is completed. This is particularly important when the RSS provider is different from the treatment provider where treatment services were initially rendered.

Following SUD Treatment

Following discharge from treatment, the assigned RSS counselor/clinician must contact the patient within two (2) business days from their last treatment service to ensure that the patient is receiving necessary support. Counselors are required to demonstrate efforts to engage a patient into the RSS benefit prior to determining that they are lost to follow-up. If patient consents to services, at least three (3) documented attempts to engage patients on three (3) separate days are required. If the counselor has neither heard from nor contacted the patient for 30 calendar days after the last attempted contact, RSS will be terminated. The RSS provider will document all follow-up contacts in the County's EHR, Sage.

For the first 60 calendar days following a patient's discharge from treatment, the RSS counselor/clinician will contact and engage the patient at a frequency according to clinical need if the patient consented to participate in RSS.

Patients lost to follow-up who reconnect for RSS more than six (6) months after treatment discharge must be screened to determine if RSS continues to be the appropriate of service for the patient.

How to Ensure Patient Engagement in Recovery Support Services

- **Ensure that patients are connected with other individuals in recovery to establish a positive recovery support network.**
- **Emphasize the patient's central role in managing their health**
- **Emphasize the use of effective self-management and coping strategies to deal with stress and setbacks**
- **Facilitate access to internal and community resources to provide ongoing self-management support to patients**
- **Facilitate autonomy by linking patients to necessary resources (e.g., vocation, education, housing, transportation) to ensure that their needs are met, and they are prepared to navigate the health and social service system independently in the future, as needed**

Service Requirements and Components

Services at this level of care includes screening or assessment (if there is a lapse between treatment discharge and RSS), Treatment Planning, substance abuse assistance, recovery monitoring (including relapse prevention), group counseling, individual counseling, case management, and discharge services.

RSS may be provided for up to:

- Six (6) hours per month for youth (ages 12 – 17)
- Seven (7) hours per month for young adults (ages 18 – 20) and adults (age 21+)

An individual can continue to receive RSS services for so long as they continue to meet DMC eligibility. A LPHA at the RSS provider site must justify continuation of RSS services. Requests for continued RSS must adhere to the following schedule:

- No sooner than the 5th month and no later than the 6th month of initiation of RSS services, and
- After each successive six (6) months thereafter according to the DMC eligibility period (Title 22 CCR § 51341.1. (h)(5)(A)(i)(ii)(e)).

Additionally, if a patient re-enrolls in treatment with any network provider at any level of care, the individual must be discharged from RSS and no services can be provided from the date of treatment re-enrollment. If treatment is not needed, the patient can immediately reengage in RSS services provided a CalOMS/LACPRS discharge was not already completed.

A CalOMS/LACPRS discharge needs to be completed when the RSS provider anticipates a patient will not reengage in RSS services, but no later than 45 days after the date of last service.

Substance Abuse Assistance

Substance Abuse Assistance is a face-to-face intervention with the patient and/or family or support system that is provided on a 1:1 basis. Services can continue as long as needed according to medical necessity.

Counseling

Individual or group counseling, with the goal being to allow the patient to gain/develop:

- Personal autonomy (managing stress, free time, activities of daily living)
- Personal care (grooming, managing finances), health, and wellness (exercise options, nutrition)
- Social Skills, coping skills and learning adaptive behaviors (coping with cravings or triggers that could result in relapse)
- Individualized Recovery Plan

Counseling services may be provided 1:1 or in group settings. Groups should consist of two (2) to 12 individuals per group and these services must be delivered face-to-face. Patients who are enrolled in RSS, outpatient (ASAM 1.0), and intensive outpatient (ASAM 2.1) can participate in the same group counseling if clinically appropriate. Patients who are enrolled in recovery support services cannot participate in the same group counseling and patient education sessions as those in residential treatment services.

Recovery Monitoring

This service provides patients with dedicated guidance and recovery management to help them learn practical strategies to prevent relapse and address real-world environmental and personal triggers for drug or alcohol misuse. Recovery Monitoring targets SUD behavior and associated symptoms of use/relapse (stress, mood, and self-efficacy). This service can be delivered face-to-face or by telephone.

Case Management

Individual service coordination, providing linkages with other services including:

- Support for education and job/life skills, employment services, job training, and legal and educational services
- Parenting support for childcare, parent education, child development support services, and family/marriage education
- Linkages to self-help and support groups, spiritual and faith-based support, and peer-delivered support services and groups
- Ancillary services such as housing assistance, and transportation. Providers should identify service gaps and link the patient to ancillary supports to help address those gaps

Case management can be delivered face-to-face or by telephone.

Relapse Prevention

Relapse prevention focuses on identifying a patient's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs.

For definitions of group counseling, individual counseling and case management, see other sections.

Required Documentation

RSS counselors/clinicians must document each patient encounter, capturing relevant recovery details such as a summary of status and progress, pertinent changes, relapse potential, etc.

RSS provided in the community and/or by telephone require equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility. Documentation guidelines and templates developed by SAPC must be used for RSS progress notes. For more information on documentation requirements, see the *Documentation* section.

Recovery Bridge Housing

Housing, and residing in a safe and stable living environment, is often critical to achieve and maintain recovery from SUDs. Research shows that SUD treatment outcomes are better for individuals experiencing homelessness, particularly chronic homelessness, when they are stably housed. Patients with SUDs need access to safe, stable, and supportive living environments to help them initiate and sustain their recovery and reduce the risk of relapse.

Recovery Bridge Housing (RBH) is defined as a type of abstinence-focused, peer-supported housing that provides a safe interim living environment for patients who are homeless according to the U.S. Department of Housing and Urban Development (HUD) definition, or unstably housed. Patients in RBH must be concurrently in treatment, particularly in the outpatient (OP), intensive outpatient (IOP), Opioid Treatment Program (OTP), or Outpatient (aka: Ambulatory) Withdrawal Management (OP-WM) settings.

The core goal of RBH is to provide a safe living space that is supportive of recovery for patients who are receiving OP/IOP/OTP/OP-WM treatment for their SUD. RBH is available for *young adults (ages 18-20) and adults (ages 21+)* who are:

1. In need of a stable, safe living environment in order to best support their recovery from SUD; and
2. Concurrently enrolled in OP/IOP/OTP/OP-WM treatment settings.

Those who are discharged from treatment in OP/IOP/OTP/OP-WM settings will no longer be eligible to receive reimbursement for RBH. However, RBH providers may hold beds for up to seven (7) days for patients who need to leave the housing facility for reasons such as hospitalization, therapeutic pass, flash incarceration, and return to treatment after discharging against medical advice. These held beds within the aforementioned timeframe and reasons are billable through the provider's RBH contract.

Certain populations, such as those experiencing homelessness, are particularly at risk for relapse without access to housing and should be prioritized for this benefit. Other vulnerable populations will be prioritized for RBH as listed in **Table 10 (see Principle, Number 2)**. Populations other than the prioritized populations listed in **Table 10** will be authorized for RBH if sufficient capacity is available to accommodate prioritized populations.

The Foundational Principles of Recovery Bridge Housing (see **Table 10**) are based on characteristics of Recovery Housing as defined by the U.S. Department of Housing and Urban Development (HUD), as well as recommendations from DHCS around best practices.

RBH aligns with the spirit of the ASAM Criteria in the sense that individuals should be appropriately placed in the least restrictive treatment environment necessary in order to meet their clinical needs. While RBH is not officially an ASAM level of care, it serves as a bridge between the more intensive and restrictive residential treatment setting and OP/IOP/OTP/OP-WM treatment with no housing component attached.

Table 10.

Recovery Bridge Housing Foundational Principles	
1	Agencies managing RBH should not restrict access to this benefit to their own patients. Agencies are required to accept referrals to available RBH beds from other network providers, and they should equally refer their patients to other available RBH beds if they have met their capacity. RBH beds should be available to any patient that is eligible for this benefit within the SUD system of care, especially those belonging to one of the groups prioritized for this benefit.
2	SAPC-contracted beds must only be dedicated for SAPC patients. Providers utilizing SAPC-contracted beds for non-SAPC patients are out of compliance with SAPC contract requirements.

3	<p>The following high-risk patient populations need to be prioritized for RBH at the SUD treatment provider level according to the following ranking (from higher priority to lower priority*):</p> <ol style="list-style-type: none"> 1. Pregnant and parenting women (pregnant to 60 days postpartum) 2. Active intravenous drug users (injected drugs within the last 30 days) 3. High utilizer patients (as defined by high utilizer criteria for high tier care management⁴) 4. Chronically homeless (according to HUD definition⁵) 5. Certain criminal justice-involved patients without alternative criminal justice funding for recovery housing 6. Young Adults (ages 18-20) 7. HIV/AIDS patients 8. Residential step down (homeless patients stepping down from residential treatment into RBH) 9. Lesbian, gay, bisexual, transgender and questioning (LGBTQ) populations <p>* Populations outside of the prioritized list will be authorized for RBH if sufficient capacity is available to accommodate prioritized populations.</p> <p><u>Note:</u> Undocumented homeless adult patients who meet the prioritization criteria listed above and are receiving concurrent SUD treatment through My Health LA or other applicable County program benefits (e.g., AB 109) are eligible for placement in RBH.</p>
4	Eligible participants should be medically and psychiatrically stable enough to benefit from RBH.
5	Program participation is self-initiated, and patient chooses abstinence-focused housing. Patients who receive RBH payment are expected to be abstinent from drugs and alcohol. However, abstinence is not defined as including abstinence from Medications for Addiction Treatment (MAT). Patients placed in RBH may and should receive MAT, when clinically indicated. RBH providers should have policies and procedures to ensure a client-centered process for when patients placed in RBH are receiving MAT.
6	Program policies and operations should be consistent with the National Standards for Cultural and Linguistically Appropriate Services (CLAS) and ensure individual rights of privacy, dignity, respect, and safety.
7	Programs should emphasize the personal recovery goals of participants and long-term housing stability so as to minimize the likelihood of homelessness.

⁴ **High tier care management inclusion criteria** – All individuals diagnosed with SUD who meet any of the following criteria:

- 3+ emergency department (ED) visits related to SUD within the past 12 months
- 3+ inpatient hospital admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD
- Homeless with SUD (as defined by HUD homelessness definition)
- 3+ residential SUD treatment admissions within the past 12 months
- 5+ incarcerations with SUD in 12 months

² HUD definition of **homelessness** includes four categories: 1) **Literally Homeless**: Individuals or families who live in a place not meant for human habitation, in an emergency shelter, or in an institutional care facility where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; 2) **Imminent Risk of Homelessness**: Individuals or families who will imminently lose their primary nighttime residence within 14 days, has no subsequent residence, and who lack the resources to obtain other permanent housing; 3) **Homeless Under Other Statutes**: includes unaccompanied youth under 25 or families with children and youth who are defined as homeless according to other federal statutes, have not been placed in permanent housing in the last 60 days, have experienced persistent instability, and are expected to remain in such status for an extended period due to special needs or barriers; and 4) **Fleeing/Attempting to Flee Domestic Violence**: An individual or family attempting to flee DV who has no other residence, and lacks the resources or support networks to obtain other permanent housing.

HUD definition of **chronic homelessness** is “a person [having] a disability and have been living in a place not meant for human habitation, in an emergency shelter, or a safe haven for the last 12 months continuously or on at least four occasions in the last three years *where those occasions cumulatively total at least 12 months*” (United States Department of Housing and Urban Development 2016).

Patients in RBH meet the HUD chronic homelessness definition. For patients who are chronically homeless upon entering RBH, they maintain their chronic homeless status even by staying in RBH for 90 days or longer.

8	Program design should establish minimal barriers for entry into programs.
9	Program must meet or exceed National Alliance for Recovery Residences (NARR) standards of care.
10	Holistic services and peer-based supports are available to all program participants.
11	Relapse is not treated as an automatic cause for eviction from housing or termination from the program.
12	Discharge from housing should only occur under two conditions – first, when a participant's behavior substantially disrupts or impacts the welfare of the recovery community in which the participant resides; and second, if the participant is no longer able to benefit from RBH due to becoming medically or psychiatrically unstable. Participants may apply to reenter the program if they express a renewed commitment to living in an abstinence-focused housing setting.
13	Participants who determine they are no longer interested in living in abstinence-focused housing or who are discharged from the program are aided in accessing other housing and service options.
14	Throughout the duration of program participation, programs are required to help patients transition into permanent housing options to ensure a smooth transition once they are ready to leave the program.

Recovery Bridge Housing Considerations

- RBH is voluntary and patients being considered for RBH need to choose to be placed in an abstinence-focused living environment in order to facilitate their recovery.
- RBH is appropriate for individuals who have minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.
- The activities provided in RBH vary, and may include peer support, group and house meetings, self-help, and life skills development, among other recovery-oriented services. Patients participating in RBH cannot access SUD treatment services and case management in RBH settings.
- SUD treatment services, including Alcohol/Drug Testing or Urine Analysis, cannot be provided in RBH. The RBH provider may coordinate with the treatment provider, and request that the test be conducted for the patient. However, patient consent must be secured to release the test result to the RBH provider.
- Individuals appropriate for RBH may be stepping down from residential treatment or may be entering the SUD treatment system directly into OP/IOP/OTP/OP-WM levels of care.
- Youth (under age 18) who require recovery housing may be eligible for placement in a group home that provides treatment and ancillary services in sites licensed by the California Department of Social Services.
- Patients participating in RBH must be screened for tuberculosis (TB) or provide evidence of having been screened (e.g., for those stepping down from residential treatment) within six (6) months prior to or 30 days after admission into RBH.
- Whenever possible and as preferred by the patient, individuals should be placed in RBH that is located within 30 minutes or 15 miles of their treatment provider.

Eligibility for Recovery
Bridge Housing

RBH is available for *young adults and adults* who meet all the following criteria:

- 1. In need of a stable, safe living environment in order to best support their recovery from a SUD; and**
- 2. Concurrently enrolled in treatment in OP/IOP/OTP/OP-WM treatment settings.**

Assessing Housing Options

Before being admitted to treatment, all SUD patients must be assessed at the SUD treatment site to which they have been referred. The assessment must include all six (6) ASAM dimensions, including ASAM Dimension 6 – Recovery/Living Environment.

Providers should begin the process of identifying and securing permanent housing immediately upon admission. Those that have received training on administering the CES screening tools and accessing the Homeless Management Information System (HMIS) should conduct a screening using the CES Survey Packet for adults (including the **Vulnerability Index-Service**

Prioritization Decision Assistance Tool (VI-SPDAT)) or the Next Step Tool for youth, within fourteen (14) calendar days of first service or intake appointment for patients identifying as experiencing homelessness at intake. Treating providers that have not received training on CES screening tools and access to HMIS must refer homeless patients to the adult or youth CES agencies within the same special planning area (SPA) within fourteen (14) calendar days of first service or intake appointment. This timeframe is intended to give SUD counselors sufficient time to work with patients to find an appropriate housing placement. For patients who are homeless along with their families, SUD treatment providers need to call 211 or refer them to the CES for Families agencies at each of the eight (8) SPAs countywide.

The CES housing screening tools triage homeless individuals based on their health and behavioral health needs to match them with appropriate housing options and services. They are a critical first step to accessing housing options beyond RBH, particularly those available through the CES. All SUD treatment providers should ensure that their staff are at least familiar with the CES and its coordinators in each of the eight (8) SPAs. For network providers that already have organizational and user agreements with the Los Angeles Homeless Services Authority (LAHSA) to access and utilize the HMIS, they should administer the CES Survey Packet (including VI-SPDAT) or the Next Step Tool with their SUD patients, and enter the information into HMIS. SUD counselors should enter and update patient information into HMIS, connect and coordinate with the CES agencies on potential housing matches, and assist patients with corresponding housing application requirements. These activities, and others that assist patients to seek permanent housing resources, are billable under Case Management. To increase access to housing resources for the SUD network providers, SAPC continues to work collaboratively with LAHSA to issue and establish more HMIS licenses and accounts.

A continuum of housing options should be available to accommodate the varied needs and preferences of homeless patients. Some homeless individuals may need short-term housing while they work to get back on their feet, while others may need access to permanent supportive housing. It is important for homeless individuals with SUDs to have access to both abstinence-focused housing in RBH, as well as low barrier housing that is available in the community via the CES that does not require abstinence. Varied housing options allow individuals who are not yet ready or able to achieve abstinence to have patient choice.

SUD providers must discuss housing preferences with patients, and combined with their professional judgment, determine if housing in RBH – which requires abstinence from drugs/alcohol and continued SUD treatment – or placement in other housing options outside of SAPC’s network is more appropriate. If non-RBH is assessed to be more appropriate, SUD providers should work with appropriate staff at CES lead agencies to match homeless individuals with available housing for which they are eligible based on their housing assessment score.

All patients being considered for RBH should first be screened for alternative access to housing through some other mechanisms. Some individuals may be eligible for or receive reimbursement for recovery housing from a funding source outside of the specialty SUD system, such as through AB 109 funding (e.g., Probation provides access to recovery residences and other housing options to AB 109 patients). Since RBH cannot be paid with Drug Medi-Cal funds, network providers should make every effort to match patients with appropriate recovery housing reimbursed by another funding source whenever possible.

Recovery Bridge Housing Authorization Process

If RBH is determined to be appropriate, SUD treatment providers must refer the patient to the appropriate RBH provider. The SUD treatment and RBH providers must coordinate very closely to ensure the patient’s safe and timely arrival at the RBH facility. The RBH provider must submit a Sage authorization request and supporting documentation to ensure the patient meets RBH eligibility criteria, and to receive payment for RBH from SAPC. The RBH provider must collaborate with the treatment provider for the submission of needed documentation, ensuring the patient’s concurrent enrollment in OP/IOP/OTP/OP-WM treatment. In instances in which the SUD treatment provider is a different agency than the RBH operator, there must be appropriate communication and policies and procedures in place between the referring and accepting providers to confirm that a bed is available and to ensure coordination between agencies. The policies and procedures between the referring and accepting providers must clearly describe the agreed upon referral and acceptable procedure, necessary coordination processes, and a clear process by which disagreements are resolved.

UM staff will review the Sage authorization request form and supporting documentation (e.g., full ASAM Continuum assessment, Treatment Plan, progress notes, and discharge/transfer plan), and render a decision on authorization which is required for an agency to receive reimbursement for RBH services. Referring treatment providers must document the need for RBH in the patient’s Treatment Plan and on the Financial Eligibility Form for RBH. Both RBH and treating providers must refer to the most recent Sage and Manual (non-Sage) versions of the SAPC Checklist of Required Documentation for Eligibility Verification and Service Authorization Requests, as posted on the SAPC website.

Duration of Recovery Bridge Housing

Young adult and adult patients may be authorized and reimbursed for 90 days, and reauthorized for an additional 90 days if needed, for a maximum stay of 180 days for patients who meet medical necessity for OP/IOP/OTP/OP-WM outpatient treatment and the RBH eligibility criteria specified above. The 180 days are not required to be continuous and may be used throughout a 12-month period starting from the date of initial RBH admission.

Pregnant and parenting women are authorized for an initial 90 days. They and may be reauthorized for another 90 days and every 30 days thereafter, up to 60 days postpartum, based on medical necessity for OP/IOP/OTP/OP-WM outpatient treatment.

Discharging Patients from Recovery Bridge Housing

SUD treatment providers should begin discharge planning regarding the housing needs of homeless patients immediately once they enter treatment. This includes working with the patient to create a housing plan for when they are discharged from treatment and will no longer be eligible for RBH. Once RBH patients complete their stay or stop receiving the benefit, the RBH provider will complete the RBH Discharge Form for each patient and submit it to Sage on the same day of discharge. If different from the RBH provider, the OP/IOP/OTP/OP-WM provider will be able to access the RBH Discharge Form in the patient's record on Sage.

Eligible Recovery Bridge Housing Providers

At this time, RBH providers are limited to current SAPC-contracted providers that have experience providing RBH to individuals receiving treatment in OP/IOP/OTP/OP-WM settings. Also, RBH providers must be members of a recovery housing organization such as Sober Living Network (SLN), or California Consortium of Addiction Programs and Professionals (CCAPP) that adheres to NARR standards and best practices. RBH providers must enter into a separate resident agreement with each patient placed in RBH. It is best practice for RBH providers to maintain a naloxone kit for overdose prevention onsite and ensure that RBH House Managers or other designated staff receive training in administering naloxone.

Staffing for Recovery Bridge Housing

RBH providers are responsible for ensuring that onsite house managers oversee the day-to-day operations of the facility. This includes ensuring adherence to policies and procedures, rules and requirements, and the quality of the facility and the health and safety of residents. RBH house managers must receive appropriate onsite orientation and training prior to performing assigned duties, have appropriate experience and necessary training at the time of hiring, and should be familiar with confidentiality regulations under 42 Code of Federal Regulations (CFR) Part 2 governing the confidentiality of substance use disorder patient records.

Other RBH personnel include trained staff responsible for completing authorization applications and other required documentation in Sage and coordinating with the treating provider if the patient is receiving treatment from another agency. Some examples of coordination include verifying with the treating provider that the patient is still concurrently receiving OP/IOP/OP-WM/OTP treatment, informing the treating provider if the patient leaves or has been discharged from RBH, reminding the treating provider to conduct housing screening and/or refer patient to permanent or alternative housing resources, and sharing with treating provider requested information to accurately complete the patient's CalOMS/LACPRS records. The RBH staff must document these coordinate efforts with the treating providers.

Physician Consultation Service

Given the shortage of medically trained addiction specialists in the SUD workforce, the Physician Consultation Service aims to build the capacity of physicians through consultation and education. It is designed to help facilitate the exchange and dissemination of addiction expertise both *between* physician providers and *within* the specialty SUD system of care for youth, young adults, and adults.

A physician consultation is a correspondence between physicians in which a Referring Physician is seeking advice, opinion, or recommendation regarding the evaluation and/or management of a specific issue from a Consultant Physician.

Physician Consultation Services available to physicians within the specialty SUD system in Los Angeles County are provided by the University of California, San Francisco (UCSF) Substance Use Warmline.

Physician Consultation Process

Referring Physicians within the specialty SUD system who seek consultation are responsible for initiating the consultation by calling the UCSF Substance Use Warmline at **(855) 300-3595** (more information available at: <http://nccc.ucsf.edu/clinical-resources/substance-use-resources/>).

Eligible Participants

Physician Consultation requests are intended for **physicians only** and must not be initiated by non-physicians or patients.

Service hours

These services are available Monday through Friday (excluding holidays) between 7 AM and 3 PM Pacific Time. Voicemail is available 24-hours per day. Every effort is made to respond to consultation requests in a timely manner.

All consultation requests must include a clear explanation as to the reason for the consultation and include any relevant history and clinical details that help to inform and provide context for the concern/question. Additional details related to consultation topics include:

- The content of the consultative advice offered through Physician Consultation Services is limited to addiction expertise, and these consultations may involve, but are not limited to, management of complex cases and questions involving MAT.
- Consultation requests that are non-clinical in nature, administrative, or more appropriate for County staff are not appropriate for this line. For example, if a physician has a question regarding Drug Medi-Cal eligibility, service availability, or questions regarding policies/procedures related to substance abuse treatment, these questions should be directed to the County. The UCSF Substance Use Warmline provides general addiction expertise and will not be able to answer non-clinical or administrative questions specific to Los Angeles County.
- For the protection of patients and involved providers, Physician Consultation Services are strictly limited to routine consultation requests. Emergent and urgent consultation needs should be directed to more appropriate resources (e.g., emergency department, psychiatric emergency services). If the Consultant Specialist determines that a consultation request is emergent or urgent, or that the consultation request is otherwise inappropriate (e.g., patient's condition not consistent with services provided by the consult service), the Referring Physician will be notified of this determination and will be provided an explanation for this decision.
- The Consultant Specialist from UCSF will utilize the information provided by the Referring Physician to provide recommendations focused on the question/concern of the

consultation request. In some complex cases and at the discretion of the Consultant Specialist, the question asked by the Referring Physician may be posed to other addiction specialists within the UCSF Substance Use Warmline to elicit alternative clinical opinions and ideas.

- In conjunction with the consultant's expert opinion, the Referring Physician will then utilize their own professional judgment and other considerations (e.g., patient preferences, family concerns, other comorbid health conditions and psychosocial factors) to provide comprehensive and patient-centered treatment that is informed by the consultation.

Documentation

Documentation expectations for services provided as a result of Physician Consultation Services are the same as documentation requirements in other patient care scenarios. A Progress Note must be completed within seven (7) calendar days by a LPHA or MD, practicing within the scope of their practice. Progress notes must include: beneficiary's name; purpose of the service; the date; start and end times of each service; and identify if services were provided face-to-face or by telephone. If the Referring Physician utilizes the Physician Consultation Service, the Referring Physician is also responsible for including thorough documentation of the patient encounter and the role of the Physician Consultation Service in informing that encounter. All documentation should use language that is clear and comprehensible to non-physician LPHA and SUD counselors.

Billing

Physician Consultation Services are provided as a free service for the specialty SUD system. The time physicians in the specialty SUD system spend seeking physician consultation is **not** a billable service.

All local, state, and federal confidentiality requirements involving HIPAA and 42 CFR Part 2 must be followed during the Physician Consultation process.

Service Delivery Options

Field-Based Services

The SUD treatment field is evolving to allow for the delivery of services in a more flexible manner that is based on patient need and established treatment goals. Flexible treatment approaches such as field-based services (FBS) and the use of a patient-centered philosophy can increase patient motivation in treatment and lead to positive treatment outcomes.⁶

FBS are a method of mobile service delivery for OP services (ASAM 1.0), IOP services (ASAM 2.1), case management, and RSS for patients with established medical necessity. FBS provide an opportunity for SUD network providers to address patient challenges to accessing traditional treatment settings, such as physical limitations, employment conflicts, transportation limitations, or restrictive housing requirements (e.g., registered sex offenders).

⁶ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (2002). *Enhancing Motivation for Change in Substance Abuse Treatment*. TIP 35. Rockville, MD.

Having FBS as a method of service delivery provides an opportunity for SAPC contracted SUD providers to address patient barriers to accessing traditional treatment settings such as physical limitations, employment conflicts, transportation limitations, or restrictive housing requirements. (e.g., registered sex offenders). FBS is intended to serve populations that have been historically difficult to serve (see **Table 11**). Utilization of FBS needs to be based on demonstrated patient need for services outside of a DMC-certified site.

FBS can only be delivered in designated, SAPC-approved sites, and in all instances, the provider delivering FBS must be linked to the contracted DMC-certified agency site that is billing for the FBS service. OTP providers wishing to provide group or individual counseling outside of their OTP program are required to obtain certification for the specific level of care. Once the required certification is obtained, providers should contact SAPC Contract Services Division.

Each DMC-certified agency is limited to five (5) FBS site locations.

Seeking Approval for Field-Based Service Sites

To obtain approval to provide FBS at a desired site, providers must submit a FBS work plan proposal request to SAPC with the rationale for a community-based service co-location. Proposals need to include data about the following:

- Proposed FBS site and target population (see **Table 11** for recommended target populations and **Table 12** for allowable FBS sites)
- Special needs of individuals who will be served in each proposed FBS site
- Volume of individuals expected to be served in the site
- Levels of care or services to be delivered (ASAM 1.0, ASAM 2.1, case management, or recovery support services)
- Frequency and hours of operation on the site
- A Memoranda of Understanding (MOU) from the host agency or organization
- Explanation of how the FBS will comply with required patient confidentiality requirements (42 CFR Part 2 and HIPAA) when they are delivered in the proposed settings.

Table 11.

Field-Based Service Target Populations
FBS is intended for those populations that have been historically difficult to serve which include, but are not limited to, the following populations: <ul style="list-style-type: none">• Arsonists• Registered Sex Offenders• Homeless• Individuals with Co-occurring Conditions• Medically Fragile• Residents of Rural Areas• Juvenile Justice-Involved• Foster Care System-Involved• Pregnant and Postpartum Women• Gang-Involved• Older Adults• Women with Children• Veterans• School-Based Youth, including Alternative School Placements

Site Limitations / Exclusions

DMC Site Certification

FBS cannot be used in lieu of obtaining California Department of Health Care Services (DHCS) DMC site certification for providers' directly operated sites (e.g., rented, leased, owned sites) where delivery of SUD or mental health treatment services are the primary business and where services are delivered by individuals employed by the agency managing the service site.

DHCS DMC site certification is not required for facilities whose primary business is the provision of services *other than SUD and mental health* and where services are delivered by individuals *not employed by the agency managing the service site*. If services are provided on a regular basis, specifically permanent, full-time co-locations, the SAPC-contracted SUD service provider must add the site location to their SAPC contract to receive DMC reimbursement for those services.

In-Custody Services

In-custody services are not permissible as a FBS delivery site and are not reimbursable through the DMC program.

Table 12. Allowable Non-Clinic Field-Based Service Sites

Allowable Non-Clinic Field-Based Service Sites	
Youth	Adults
<ul style="list-style-type: none"> • Youth Homeless Shelters • Group Homes • Community Facility Centers • Community Centers • Recreation Centers • Department of Children and Family Services Offices • Probation office sites/regional hubs • Los Angeles County Office of Education Alternative sites • SAPC approved school sites 	<ul style="list-style-type: none"> • Adult Day Centers • Board and Care settings • Federally Qualified Health Centers • Drop-in centers • Department of Mental Health (DMH) clinic sites (including DMH legal entities) • Department of Health Services (DHS) directly-operated facilities • Department of Probation Area Offices • Department of Children and Family Services Offices • Department of Public Social Services Office • Temporary or Permanent Supportive Housing Locations

Field-Based Service Procedures

1. If during the intake process an SUD counselor/clinician determines that a patient is a member of at least one of the target populations highlighted in **Table 12**, the counselor/clinician needs to assess if FBS as a delivery option is necessary and appropriate for the patient.
2. If it is determined that the patient would be better served by FBS as compared to a more traditional service delivery method, the counselor/clinician must submit documentation.
3. The SUD counselor/clinician must work with the patient to develop a Treatment Plan that includes goals specific to FBS.
 - FBS goals must be explicitly included in the Treatment Plan in order to be billable.
 - The Treatment Plan for FBS must include the anticipated number of FBS sessions to be provided and the FBS site location that was approved.
4. Minimum FBS service expectations include:
 - Providing culturally, linguistically, and developmentally competent services
 - Utilizing a biopsychosocial approach, including education regarding medication-assisted treatment, when applicable and necessary
 - Using evidence-based practices such as Motivational Interviewing and Cognitive Behavioral Therapy
 - Using case management to facilitate care coordination and access to necessary health and social services
 - Compliance with applicable legal and regulatory obligations, including confidentiality requirements (e.g., HIPAA and 42 CFR Part 2)
5. The same treatment and discharge procedures for OP (ASAM 1.0), IOP (ASAM 2.1), case management, and recovery support services apply to patients receiving FBS.
6. Documentation expectations for FBS are identical to that of other services delivered throughout the specialty SUD system. It is critical that SUD counselors/clinicians clearly

document all FBS rendered to patients, including but not limited to: specifying the type of FBS service delivered, duration, and location of service delivery.

Components of Field-Based Services

1. Assessment and Patient Outreach

- Agencies may opt to utilize FBS to conduct ASAM Continuum or SAPC Youth ASAM assessments and outreach. However, only services rendered to individuals who meet medical necessity will be reimbursable. Thus, agencies that opt to utilize FBS to conduct Continuum or SAPC Youth ASAM assessments and outreach should acknowledge that time spent conducting assessments for individuals that do not ultimately meet medical necessity are not reimbursable. Additionally, work plans submitted for assessments will not be approved for sites with co-located CENS.

2. Direct SUD Treatment Services

- FBS outpatient, IOP services and case management may be provided on an individual or group basis. Groups should have at least two (2) and can be no more than twelve (12) individuals per group. Individuals must meet medical necessity based upon the ASAM Criteria in order to access the following service components:

FBS Components (refer to OP Treatment section for full description of services)

- Individual Counseling
- Group Counseling
- Case Management
- Patient Education
- Family Therapy
- Collateral Services
- Recovery Support Services

Field-based Service Site Approvals

Prior to initiating FBS, contractors must submit a completed work plan summary and narrative (see Work Plan Summary on the SAPC website under Field Based Services) to SAPC for review and approval. The purpose of the work plan is to:

- Identify the proposed non-clinic settings and target populations to be served (see **Table 11** for recommended target populations and **Table 12** for allowable FBS sites);
- Demonstrate that FBS will comply with required patient confidentiality and security for records requirements (42 CFR part 2 and the Health Insurance Portability and Accountability Act (HIPAA) when they are delivered in the proposed settings;
- Describe the frequency and duration of service provision in field-based locations.

SAPC will require a written agreement such as Memorandum of Understanding (MOU), Service Delivery Agreement (SDA), etc. between the contractor and the agencies/organizations that will host the provider of FBS including school-based sites. SAPC reserves the right to deny approval of work plans at its sole discretion at any time.

The County maintains full discretion to approve and deny FBS work plan proposals at any time. Agencies conducting FBS at sites not listed on the approved work plan will be disallowed and may have their approved FBS work plan revoked.

Telehealth and Telephone

SAPC does not currently reimburse for telehealth services but does reimburse for eligible telephone services. Calls must be documented and made from a DMC-certified location. Eligible telephone services include:

- Crisis intervention
- Individual Counseling
- Collateral Services
- Case Management
- Recovery Support Services

Intake and Enrollment

It is important to establish a comprehensive and standardized intake and enrollment process that balances the need for information with the need to create a streamlined and patient-centered experience for the patient. The sections below describe essential components of the intake process.

Required Forms

Patient Rights

Patient rights assure that the basic rights of independence of expression, decision and action, concern for personal dignity, and human relationships are preserved for all patients. As a cornerstone of a patient-centered and effective treatment system, specialty SUD providers must share an individual's patient rights with them in writing, either collectively or individually.

Patient Handbook

The County's *Substance Use Services Patient Handbook* outlines the benefit package for Medi-Cal, My Health LA, and individuals participating in the other County funded partner projects (e.g., AB 109). It also includes information on eligibility, accessing network providers that meet patient needs and preferences, patient rights and responsibilities and the grievances/appeals process. This document must be provided within five (5) days of first service by one of the following ways and at no-charge to the patient:

1. Provide a printed copy or mail it to the patient's mailing address.
2. Email a copy after obtaining the patient's agreement to communicate by email.
3. Direct the patient to the County's website for viewing.

Regardless of the selected scenario, Network Providers are required to provide the patient with a copy of the County's Patient Handbook Summary and document the distribution format selected. If at any time the patient requests a printed copy, the Network Provider must provide it at no-charge. The Patient Handbook will be available on SAPC's website in all threshold languages.

The [Patient Handbook Summary](#) must be signed by the patient and the signature page must be stored within your electronic health record system for all new admission as of April 1, 2018. For primary Sage users, please use the following title “Patient Handbook Summary (##-##-##)” that includes the date signed (e.g., Patient Handbook Summary (04-01-18)). While use of this form is only required for admissions on or after April 1, 2018, it is recommended for any current clients unless you already have documentation in another format. The form is currently only available in English but will be translated into other threshold languages.

Notice of Privacy Practices

Los Angeles County’s Notice of Privacy Practices explains patient rights and the treatment agency’s legal duties with respect to patient health information. It must be made available to all new and continuing patients within five (5) business days of first services.

The Notice of Privacy Practices is available in English and Spanish on SAPC’s website.

Confidentiality / Release of Information

SUD treatment providers within the specialty SUD system must thoroughly explain confidentiality options to patients and have them sign the necessary confidentiality forms (e.g., DPH-SAPC Release of Information Form, both within the SAPC SUD provider network and with external providers). All confidentiality and release of information forms must comply with 42 C.F.R. Part 2, HIPAA, and other pertinent regulations.

As indicated on the DPH-SAPC Release of Information Form, patients can elect to consent to share information with the entire SUD network of providers (**Option 1**) or consent only to specific SUD providers (**Option 2**). The benefits, risks, and alternatives to these options, must be discussed with patients to allow them to make informed decisions about their care. Patients must sign the DPH-SAPC Release of Information Form for it to be finalized.

Why Encourage Information Sharing?

The SUD system is moving into a new era that encourages information sharing with physical and mental health systems to improve care coordination and health outcomes.

It is important to support appropriate information sharing as SUD patients often have other health conditions that complicate care and can prevent long-term achievement of recovery goals if un/under treated.

Importantly, after the patient elects either Option 1 or 2 on the DPH-SAPC Release of Information Form, providers using Sage, SAPC’s electronic health record system, must indicate the patient’s consent option by going on the Consent Form page within Sage and selecting the providers the patient is interested in releasing information to. This process translates the patient’s desires with regard to consent to release information into Sage. Similar to the DPH-SAPC Release of Information Form, there is also the option within Sage to select all providers and consent to share information with all SUD network providers, or to select only specific providers within the SUD network to share information. Once the Consent Form page within

Sage is completed, providers must upload the signed DPH-SAPC Release of Information Form into Sage.

If the patient is transferring from a new location, providers must ensure that consent forms are signed and appropriately utilized to ensure information exchange while maintaining compliance with applicable confidentiality regulations.

SUD treatment providers within the specialty SUD system must update the Release of Information and consent forms that patients sign. Providers must also upload the latest documents to Sage so that other network providers have access to the latest versions of these documents to facilitate information exchange.

If patients revoke consent to disclose information to a specific SUD provider within the network, SUD treatment providers must notify involved entities of this update.

Patient Informing – Consent for Treatment and Information Sharing

The foundational principle of consent for treatment is that individuals must give permission before they receive any type of health treatment, test, or examination.

Informed consent generally includes:

- The nature of the decision, treatment, and/or procedure
- Reasonable alternatives to the proposed intervention
- The relevant risks, benefits, and uncertainties related to each alternative
- Assessment of patient understanding
- The acceptance of the intervention by the patient

It is critical that SUD providers thoroughly describe and explain the services that are recommended to give patients the information necessary to make informed decisions regarding the care that is being proposed.

Additionally, the intake process needs to include consenting patients for information sharing purposes. Sharing information with other SUD and physical/mental health providers is essential in order to provide coordinated care that is in the best interests of patients. As such, thorough information regarding confidentiality (HIPAA and 42 CFR Part 2) needs to be provided to patients in order to obtain informed consent for information sharing purposes that balances the need to maintain necessary privacy and the need to share information to provide high-quality and coordinated care.

In order to be valid, the consent process must be free of coercion, voluntary, and the patient giving consent must have decision-making capacity and be deemed competent to make the decision at hand.

Patient Informing – Complaint/Grievance and Appeals Process

All patients served within the specialty SUD system in Los Angeles County have access to a complaint/grievance and appeals process to, respectively, either express dissatisfaction or request reconsideration for an action taken by either the provider or County (e.g., denial of a requested service).

Patients need to be informed about their rights and the availability of a due process to file complaints/grievances and appeals, both at the level of the treatment providers and when there are concerns that are more appropriately addressed to the County. Patients should be given a form to sign indicating they have been informed of their rights. This signed form should be maintained in the patient file. These complaints/grievances and appeals may either be filed by the patient, provider, or another designated entity.

See *Complaints/Grievances and Appeals Processes* section for additional details.

Required Processes

Assessment

Part of the intake process involves assessing the patient by using a full ASAM Continuum or SAPC Youth ASAM assessment to determine medical necessity and confirm level of care placement. See the *Assessment* section for further information on assessment.

Treatment Plan Development and Updates

SUD treatment providers must prepare individualized written Treatment Plans in coordination with the patient and based on information obtained during the intake and assessment process. The Treatment Plan must be completed upon intake and submitted within the following timeframe:

- **Within seven (7) calendar days of first service/first intake appointment for young adults and adults (ages 18+); or**
- **Within 14 calendar days of first service/first intake appointment for youth (ages 12-17).**

Every attempt must be made to complete and obtain patient and LPHA/Medical Director signatures within the stated timeframe. However, given that it may take time for the patient to sign and print their name the Treatment Plan, the provider must obtain both patient and LPHA signature no later than 30 days of first service/first intake appointment (**28 days for OTP patients**). The LPHA or Medical Director must then sign and print their name on the Treatment Plan within 15 days of the patient signing. These are maximum timeframes and the ideal scenario is to complete and sign the Treatment Plan as expeditiously and close to the treatment admission date as possible.

The minimum timeframes for Treatment Plan reviews and updates depend on the level of care in which treatment is delivered (see **Table 19** and *Treatment Plan* within the Documentation section for additional details). Treatment Plan updates must be completed and signed by both the patient and the LPHA, and counselor, if applicable

Treatment Plans must include:

- A statement of problems to be addressed that are consistent with the qualifying diagnosis.
- Goals to be reached which address each problem.
- Action steps to be taken by the provider and/or patient to accomplish identified goals.
- Target dates for accomplishment of action steps and goals.
- A description of services including the type of counseling to be provided and the frequency thereof as well as steps taken to complete the physical exam.
- The proposed type(s) of interventions/modalities that includes frequency and duration of intervention(s).

- Specific quantifiable goals and treatment objectives (e.g., SMART goals that are Specific, Measurable, Attainable, Realistic, and Time-bound) related to the patient's SUD diagnosis and multidimensional assessment.
- A DSM diagnosis for a SUD, or "at-risk" justification for Youth (ages 12 – 17) and Young Adults (ages 18 – 20).
- The assignment of a primary therapist or counselor
- Physical exam goal or documentation

Physical Examination

Physical exams are required to ensure that patients are medically stable and receiving the physical health services they need to facilitate biopsychosocial well-being.

Patients are required to have a physical examination within the last twelve (12) months on file. The physician/nurse practitioner/physician assistant is responsible for reviewing documentation of the most recent (**within the last twelve (12) months**) physical examination within thirty (30) calendar days of the beneficiary's admission to treatment. If documentation is not available, the provider (**registered or certified counselor or LPHA**) must include a Miscellaneous Note detailing efforts made to obtain this documentation. If a physical examination is not on file, a physical examination must occur within thirty (30) calendar days of the patient's admission or the physical exam will need to be incorporated into the Treatment Plan as a goal with a specified date of completion.

Data Reporting

Treatment providers within the specialty SUD system in Los Angeles County are required to report data into the County's electronic data collection system formerly known as the Los Angeles County Participant Reporting System (LACPRS). CalOMS/LACPRS is now integrated into Sage and includes performance and outcome measures designed to inform and shape policy and practice.

These metrics help to ensure an evaluation system for the specialty SUD system that allows for continuous improvement and high quality clinical care at the system, provider, and patient level. As such, ensuring data integrity is of the utmost importance and to the benefit of both the County and its providers. For this reason, this must be completed within seven (7) calendar days for adults (ages 18+) or within 14 calendar days for youth (ages 12-17) from the first and last treatment service.

Providers are required to develop internal processes to support data integrity efforts.

The County recognizes the importance of sharing performance and outcome data with its provider network and encourages providers to leverage available data analytic tools within Sage and their EHRs to allow for the detailed analysis of their provider- and patient-level data.

Additionally, since DHCS requires submission of CalOMS/LACPRS data for all individuals who are served within county systems, CalOMS/LACPRS data must be entered for each non-SAPC reimbursed patient who participates in a group with SAPC-reimbursed patients.

Treatment Service Components

Below is a description of various Treatment Services that are available to patients served within the specialty SUD system. These services are available to patients receiving outpatient, intensive outpatient, residential, withdrawal management and opioid treatment programs. See the sections above on additional services including screening, assessment, case management and recovery support services. For more information on how these services are billed and any service minimums or maximums, see the SUD Treatment Services Rates and Standards Matrix and the Staffing Grid.

Group Counseling

Group Counseling sessions are designed to support discussion among patients, with guidance from the facilitator to support understanding and encourage participation, on psychosocial issues related to substance use. This does not include recreational activities, skill building sessions (e.g., employment, education, tutoring), or time spent viewing videos/DVDs (although discussion time is generally allowable). Group Counseling sessions need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques. To ensure that patients are aware of upcoming Group Counseling and Patient Education sessions, a monthly calendar must be posted in areas accessible to patients which includes the topic, location, date, time and facilitator name of upcoming sessions.

Group Counseling sessions are available at all levels of care and are defined as face-to-face contact between up to two (2) registered or certified SUD counselors or LPHAs, and between two (2) to twelve (12) patients at the same time. This includes family members, non-My Health LA (MHLA), and non-Medicaid (Medi-Cal) participants. Only eligible patients (Medi-Cal or MHLA participants, or individual participating in a County funded program such as AB 109 receiving treatment can be claimed to SAPC.

Services are reported in 1-minute (1 unit) increments with sessions ranging from 60 to 90 minutes in length. A separate Progress Note must be written for each participant and documented in the EHR or Sage. Group sign-in sheets must include signatures and printed names of all participants (including participants not reimbursed by SAPC and family members) and group facilitators, date, start/end times, location, and group topic.

The frequency of Group Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Patient Education

Patient Education sessions are designed to enable the facilitator to teach participants and encourage discussion among patients on research-based educational topics such as addiction, treatment, recovery, and associated health consequences with the goal of minimizing the harms of SUDs, lowering the risk of overdose and dependence, and minimizing adverse consequences related to substance use. This does not include recreational activities, skill building sessions (e.g., employment, education, tutoring), or time viewing videos/DVDs (although discussion time is generally allowable). Patient Education sessions need to include evidence-based practices that incorporate youth or adult learning styles and support information retention. To ensure that patients are aware of upcoming Group Counseling and Patient Education sessions, a monthly calendar must be posted in areas accessible to patients which includes the topic, location, date, time and facilitator name of upcoming sessions.

Patient Education sessions are available at all levels of care and are defined as face-to-face contact between up to two (2) registered or certified SUD counselors or LPHAs, and between two (2) to twelve (12) patients at the same time in non-residential settings and between two (2) to thirty (30) patients at the same time in residential settings. Patient Education sessions may include family members and legal guardians. Services are reported in 15-minute increments with sessions ranging from 60 to 90 minutes in length. A separate Progress Note documenting the Patient Education session must be written for each participant and documented in the EHR or Sage. Group sign-in sheets must include signatures and printed names of participants and group facilitators, date, start/end times, location, and group topic.

The frequency of Patient Education sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Individual Counseling

Individual Counseling sessions are designed to support direct communication and dialogue between the staff and patient and focus on psychosocial issues related to substance use and goals outlined in the patient's individualized Treatment Plan. Individual Counseling sessions need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques.

Individual Counseling sessions are available at all levels of care and are defined as face-to-face or telephone contact between one (1) registered counselor, certified counselors or LPHA, and one (1) patient at the same time. A trainee may observe for training purposes if permitted by the patient. Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. Individual Counseling sessions less than 15 minutes cannot be billed as they are less than the minimum requirement. If Individual Counseling sessions exceed 60 minutes, the Progress Note for that encounter must substantiate exceeded time. If the counseling session is split into different services (e.g. Case Management, Crisis Intervention, etc.), a Progress Note must be written for each session and documented in the EHR or Sage.

The frequency of Individual Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Crisis Intervention

Crisis Intervention sessions include direct communication and dialogue between the staff and patient and are conducted when:

- 1) A threat to the physical and/or emotional health and well-being of the patient arises that is perceived as intolerable and beyond the patient's immediately available resources and coping mechanisms; or
- 2) An unforeseen event or circumstance occurs that results in or presents an imminent threat of serious relapse.

These sessions are immediate and short-term encounters that focus on (1) stabilization and immediate management of the crisis, often by strengthening coping mechanisms and (2) alleviating a patient's biopsychosocial functioning and well-being after a crisis. Crisis

Intervention sessions need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques.

A component of this service includes linkages to ensure ongoing care following the alleviation of the crisis. Crises that are not responsive to intervention need to be escalated to urgent (e.g., urgent care clinic) or emergent (e.g., medical or psychiatric emergency room) care. Crisis situations should not be confused with emergency situations, which require immediate emergency intervention, such as calling 911.

Crisis Intervention sessions are available at all levels of care and are defined as face-to-face or telephone contact between one (1) registered/certified counselor or LPHA, and one (1) patient at the same time. Services may, however, involve a team of care professionals. Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. A Progress Note must be written for each session and documented in the EHR or Sage.

Crisis Intervention sessions are not scheduled but need to be available to the patient as needed during the agency's normal operating hours or in alignment with afterhours crisis procedures.

Family Therapy

Family Therapy is a form of psychotherapy that involves both patients and their family members and uses specific techniques and evidence-based approaches (e.g. family systems theory, structural therapy, etc.) to improve the psychosocial impact of substance use and the dynamics of a social/family unit. Sessions also need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques.

Family Therapy sessions are available at all levels of care and are defined as face-to-face contact between one (1) therapist level LPHA, one (1) patient and their family members. Services are billed in 15-minute increments with sessions ranging from 15 to 60 minutes. A Progress Note must be written for each session and documented in the EHR or Sage.

The frequency of Family Therapy sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Collateral Services

Collateral Services are sessions between significant persons in the life of the patient (i.e., personal, not official or professional relationship with patient) and SUD counselors or LPHAs used to obtain useful information regarding the patient to support the patient's recovery. The focus of Collateral Services is on better addressing the treatment needs of the patient.

Collateral Services sessions are available at all levels of care and are defined as face-to-face or telephone contact between one (1) SUD counselor or LPHA, one (1) patient and significant persons in the patient's life. Services are billed in 15-minute increments with sessions ranging from 15 to 60 minutes. A Progress Note must be written for each session and documented in the EHR or Sage.

The frequency of Collateral Services sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Alcohol and Drug Testing

Alcohol and drug testing is the examination of biological specimens (e.g., urine, blood, hair) to detect the presence of specific drugs and determine prior drug use. While there is not a widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment effectiveness and progress to inform treatment decisions. The frequency of alcohol and drug testing should be based on the patient's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued alcohol and/or drug use has been identified to be more common. In general, alcohol and drug testing should not exceed more than twice (2x) a week.

Drug testing is best when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) should ideally vary as well. If body fluids testing (urinalysis) is performed, the patient's emission of the urine must be collected and observed by an employee with the same gender to protect against the falsification and/or contamination of the urine sample. The treatment agency should take care to be respectful of the patient and patient privacy during the specimen collection process of drug testing.

Drug Testing as a Therapeutic Tool

Drug testing should be viewed and used as a therapeutic tool. A punitive approach to drug testing generally does not facilitate a productive relationship with patients and should be avoided.

Consequences to drug testing should also be communicated in a therapeutic manner.

Decisions about appropriate responses to positive drug tests and relapses should take into account:

- The chronic nature of addiction
- That relapse is a manifestation of the condition for which people are seeking SUD treatment
- That medications or other factors may at times lead to false or appropriately positive drug test results

Alcohol and Drug Testing is allowable at all levels of care. While it is not a reimbursable service, a Progress Note must be written for each test and the service reported in the EHR or Sage.

Medications for Addiction Treatment Within All Levels of Care

Research has shown that for the treatment of addiction, a combination of medications and behavioral counseling is more successful than either intervention alone. For this reason, medications for addiction treatment (MAT) needs to be part of a comprehensive,

biopsychosocial approach to the treatment of SUDs that includes psychosocial interventions such as counseling, behavioral therapies, case management, and care coordination.

MAT needs to be discussed and offered as a concurrent treatment option for appropriate individuals with an alcohol and/or opioid related SUD condition at all levels of care. Acceptance or refusal must be documented in patient charts. Each network provider must develop policies and procedures governing the provision of MAT or linkages to other providers who offer MAT services. Network providers that do not offer MAT must establish referral relationships with Opioid Treatment Programs and/or MAT prescribers. The passive or active discouragement of the use of addiction medications that have been approved by the U.S. Food and Drug Administration (FDA) is contrary to the science of effective SUD treatment.

There are currently several FDA-approved medications for the treatment of various types of addiction in adults, as indicated in **Table 13**.

MAT as a Core Component of SUD Treatment

While psychosocial interventions such as counseling are critical to achieving recovery, the use of medications for the treatment of addiction are also oftentimes essential for recovery.

Similar to how medications are commonly accepted and can help with the treatment of other chronic conditions, MAT can help to alleviate alcohol- and opioid-related cravings, and ease withdrawal symptoms. As such, MAT is an evidence-based tool to facilitate recovery and improve outcomes and is best practice and a core component of SUD treatment for individuals for whom it is clinically appropriate.

Table 13. Medications for Addiction Treatment Options

Opioid Use Disorder	Alcohol Use Disorder	Tobacco Use Disorder
Methadone (approved to treat individuals age 16 and older if federal prerequisites are met)	Naltrexone (oral and long-acting injectable formulations)	Varenicline
Buprenorphine (approved to treat individuals age 16 and older, when clinically appropriate)	Disulfiram	Bupropion
Naltrexone (oral and long-acting injectable formulations)	Acamprosate	Nicotine Replacement Therapy
Naloxone (approved for opioid overdose prevention)		

Current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. The use and dosages of MAT should also be carefully considered in the treatment of elderly and adolescent populations, who oftentimes require unique treatment approaches given variable body composition and metabolism. MAT is currently only FDA-approved for those over the age of 18, with the exception of methadone and buprenorphine, which can be prescribed in youth age 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber. To prescribe MAT to minors under Drug Medi-Cal

requires written consent of a parent or guardian and granted exception that complies with California Code of Regulations, Title 9, Section 10425.

MAT includes obtaining informed consent, ordering, prescribing, administering, and monitoring of all medications for SUDs. When MAT is part of the Treatment Plan, licensed prescribers operating within their scope of practice should assist the patient to collaborate in clinical decision-making, assuring that the patient is aware of all appropriate therapeutic alternatives. Informed consent for all pharmacotherapies must be obtained, including discussion about the advantages and disadvantages of MAT, taking into consideration the benefits, side effects, alternatives, cost, availability, and potential for diversion, among other factors.

To provide MAT services, a network provider either needs to be (1) an Opioid Treatment Program contractor or (2) a Medi-Cal fee-for-service provider. All MAT must be prescribed in accordance with generally accepted standards of medical practice and best practice guidelines for the condition being treated.

Medication Services and Safeguarding Medications

Medication Services include the prescription, administration, or supervised self-administration (in residential settings) of medication related to SUD treatment services or other necessary medications. Medication Services may also include assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure. Safeguarding of medications in accordance with regulations is required in residential and withdrawal management settings, and may be performed by qualified staff (e.g., Licensed Vocational Nurses [LVN] or Medical Assistants [MA]). However, LVNs/MAs are not billable providers for treatment services as they do not fall under the LPHA, licensed-eligible LPHA, or certified counselor categories. Therefore, services rendered by LVNs/MAs will not be reimbursed by SAPC, other than in the instance of LVNs/MAs performing activities of Safeguarding Medications. Refer to the **Provider Staffing Grid** on SAPC's website for a complete list of staff that may assist with Medication Services.

Medication Services are available at all levels of care and are defined as face-to-face contact between patients and qualified medical staff (e.g., physicians, nurse practitioners, or physician assistants), as related to the use of FDA-approved MAT, or other necessary medications. Medication Services are reported in 15-minute increments with sessions ranging from 15 to 30 minutes in length. A separate Miscellaneous Note or Progress Note must document the encounter for each participant.

Importantly, Medication Services provided in residential settings require Incidental Medical Services approval from the State for the specified residential site. Despite this allowance from the state, there is not a current mechanism in place for billing. As a result, Medication Services provided in residential settings are not DMC reimbursable.

Non-Emergency Transportation

Providers need to make every effort possible to provide transportation or make arrangements for transportation to and from medically necessary, but non-emergent, treatment.

Non-emergency medical transportation services may be covered by the patient's managed care health plan (L.A. Care and Health Net). Transportation services require a pre-authorization from

the health plan, and it is the patient's case managers responsibility to arrange for services ahead of time. The time spent coordinating transportation services is billable under Case Management, but not the transportation services. The time it takes for staff to go to and from a field-based services location or case management activities cannot be claimed as part of the billable unit of service tied to the patient (e.g., 15-minutes at \$29.63 for ASAM 1.0).

For each network provider with a Drug Medi-Cal (DMC) Perinatal Contract with DPH-SAPC, and a current DMC Perinatal Designation on the site's DMC certification, non-emergency transportation is billable under Perinatal Transportation (up to 80 miles or \$40.80 per month) at every Level of Care. See Pregnant and Parenting Women section for more information.

Also, select costs can be added in the budget which includes but is not limited to transporting patient to and from medical appointments, mileage for staff vehicle (a log for odometer readings before and after trip must be properly maintained) or provider vehicle costs (e.g., gas, maintenance, depreciation). Bus and metro tokens can also be included in the budget, provided a log of total purchases and distribution to each patient is maintained and available to auditors upon request. Ride share services (e.g., taxi, Uber, Lyft) cannot be included in the budget.

Transportation costs must be reported under the "Transportation" line item under "Services and Supplies" category and be clearly tracked and managed. While transportation costs are included in the day-rate for residential treatment, transportation is not billable as separate service in residential. However, for Non-Emergency Transportation services to count towards the Residential weekly treatment hour standard, providers must document in a Miscellaneous Note how transportation is contributing to patient care and recovery. Start and end times per trip must be captured in the note.

Discharge Planning

Discharge planning is the process of preparing the patient for referral into another level of care, post-treatment return, or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. The discharge planning process should be initiated at the onset of treatment services to ensure sufficient time to plan for the patient's transition to subsequent treatment or recovery support services. It also helps to convey that recovery is an ongoing life process not a unit of service. Transition to RSS needs to be included as part of this process. Discharge planning should identify a description of the patient's triggers, a plan to avoid relapse for each of these triggers and an overall support plan.

Discharge Planning sessions are available at all levels of care and are defined as face-to-face or telephone contact between one (1) registered counselor, certified counselors or LPHA, and one (1) patient at the same time. A trainee may observe for training purposes if permitted by the patient. Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. A Progress Note must be written for each session and documented in the EHR or Sage.

The Discharge Form is required to be completed on the day of the last face-to-face treatment/ telephonic contact, or oral medication (OTP) for all LOCs, unless the patient's discharge is unplanned. If a patient's discharge is unplanned, the Discharge Form is required to be completed within 30 calendar days of the last day that services were provided. For Recovery Bridge Housing, the RBH Discharge Summary Form is required to be completed for each patient and submitted into Sage at the time of discharge from RBH.

Culturally, Linguistically, and Population-Appropriate Services

Cultural competence and humility includes building knowledge of and respect for the multidimensional and complex ways language and culture (inclusive of race, faith, ethnicity, abilities, gender identity, class, sexual orientation, housing and education) is experienced individually and impacts personal interactions. It is a critical component of high quality SUD services.

Treatment agencies are expected to ensure that their policies, practices, and procedures facilitate the provision of culturally, developmentally, and linguistically appropriate services. These principles should be embedded in the organizational and day-to-day. Research indicates that a lack of cultural competency in the design and delivery of services can result in poor outcomes in access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response.

Core practices that address cultural competence and humility include:

- Developing patient-centered attitudes, beliefs, values, and skills at the provider level
- Policies and procedures that clearly state and outline the requirements for the quality and consistency of care (e.g., Notice of Non-Discrimination, language taglines)
- Readiness and availability of administrative structures and procedures to support such commitments (e.g. leadership and staff that reflect the primary populations, staff training)

Providers are Required to Deliver Culturally, Developmentally, and Linguistically Appropriate Services

Providers need to ensure that their policies, procedures, and practices are consistent with this requirement, and that these principles are embedded in both the organizational structure and day-to-day operations of their agency (e.g. Personnel recruitment/retention, equal access to services, assessment of accessibility, linguistic and cultural needs, etc.). This also includes provisions for:

1. Services provided in Los Angeles County's threshold languages or in the individual's preferred language (if not one of the threshold languages)
2. Written material provided in threshold languages of populations served
3. Culturally relevant and competent services (i.e., demonstrate a respect for the diverse cultural, ethnic, and linguistic needs of the primary population served)

SAPC is committed to promoting a service delivery system that treats individuals within the context of their language, culture, ethnicity, gender identity, age, sexual orientation, development stage, and any physical, psychiatric, or cognitive disabilities.

Providers must be compliant with all elements of the Americans with Disabilities Act. The SAPC website provides resources and additional information about how to implement culturally competent services.

Special Populations

Co-Occurring Disorder Population

For the purposes of this document, co-occurring disorders (COD) are defined as when an individual has a combination of any SUD or any mental health condition, though individuals with COD can have physical health conditions as well. The COD must meet the diagnostic criteria independently from the other condition and cannot simply be a cluster of symptoms resulting from a single disorder. The significant co-morbidity of SUDs and mental illness (typically reported as 40 percent to 80 percent depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting.

According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse Treatment for Persons with Co-Occurring Disorders," consensus panel members recommend the following guiding principles in the treatment of patients with CODs:

- **Employ a recovery approach** – The recovery perspective essentially acknowledges that recovery is a long-term process of internal change that requires continuity of care over time and recognizes that these internal changes proceed through various stages, and that treatment approaches need to be specific to the goals and challenges of each stage of the COD recovery process.
- **Adopt a multi-problem viewpoint** – Treatment comprehensively addresses the immediate and long-term needs of the multidimensional problems typically presented by patients with COD. (e.g., housing, work, health care, a supportive network).
- **Develop a phased approach to treatment** – Treatment phases generally include engagement, stabilization, treatment, and continuing care, which are consistent with, and parallel to, the various stages of recovery. Treatment through these phases allows providers to develop and use effective, stage-appropriate treatment interventions.
- **Address specific real-life problems early in treatment** – Given that CODs often arise in the context of social and personal problems, addressing such problems is often an important first step toward achieving patient engagement in continuing treatment.
- **Plan for the patient's cognitive and functional impairments** – Patients with a COD often display cognitive and functional impairments that affect their ability to comprehend information or complete tasks. As a result, services need to be tailored to and compatible with the need and functional level of COD patients.
- **Use support systems to maintain and extend treatment effectiveness** – Given that many patients with a COD have strained support systems, and the central importance of supportive people and environments in the recovery process, a vital element of effective treatment of the COD population is ensuring that patients are aware of available support systems and motivated to use them effectively.

An important component of being able to develop a therapeutic alliance with the patient with a COD is the counselor or clinician's own comfort level in working with the patient. Some SUD counselors/clinicians may find some patients with significant mental health conditions threatening or unsettling, and likewise, some mental health clinicians may feel uncomfortable or intimidated by patients with SUDs. As a result, it is critical for the counselor/clinician to recognize these feelings so that they can develop strategies to avoid allowing them to interfere with the treatment of the patient with a COD. Oftentimes, these reactions can eventually be overcome with further experience, training, supervision and consultation with a supervisor or peer, and mentoring.

Optimal Treatment of Co-Occurring Disorder Population

Research has generally supported that the ideal approach toward treatment for CODs is to address all conditions simultaneously, as opposed to addressing the SUD and mental health condition separately and in a silo of separate treatment approaches. When providers have staff that possess the skills and training to adequately address the needs of the COD population within their scope of practice, integrated care is best provided in-house. However, if providers are unable to provide necessary services to this population, patients with CODs should receive appropriate referrals to providers who are able to deliver these necessary services.

While SUD counselors and staff are not expected to diagnose mental health disorders, it is important that they familiarize themselves with the terminology, criteria, and how to identify if there may be mental health concerns that may benefit from referral to other health providers. In order to meet the needs of this population, SUD counselors and clinicians need to receive training designed to help them better understand the signs and symptoms of mental disorders and how and when to access medical or mental health support.

Appropriate staffing is a key element of effectively addressing the needs of the COD population. An organizational commitment to professional development, skills acquisition, values clarification, and competency attainment is necessary to implement integrated care programs successfully and to maintain a motivated and effective staff. Ideally, enhanced staffing for patients with a COD at SUD treatment sites would include mental health professionals, and vice versa at mental health treatment sites. Alternatively, establishing appropriate referral relationships and referral processes and protocols can also help to ensure comprehensive and necessary care for individuals with a COD.

Psychosocial interventions that have been demonstrated to be effective for the COD population include motivational enhancement, contingency management, relapse prevention, and cognitive-behavioral techniques. These strategies need to be tailored to the patient's unique stage of recovery and can be helpful even for patients whose mental disorder is severe. For patients with functional and cognitive deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Finally, 12-Step and other dual recovery mutual self-help groups may be valuable as a means of supporting individuals with COD, and counselors and clinicians often play an important role in facilitating participation in such groups. In general, the ability to balance the need for empathy and support, and the need to be firm, is essential in maintaining the therapeutic alliance with a patient who has a COD. A straightforward and factual presentation of conflicting material or of problematic behavior in an inquisitive and caring manner can be both "confrontational" and caring at the same time.

The use of appropriate psychotropic medications and medications for addiction treatment are an essential component of the treatment of individuals with a COD. Oftentimes the appropriate use of medications can help patients with a COD stabilize and control their symptoms so that they can better focus on their recovery for either their SUD or mental health condition. Research has clearly demonstrated that medications used in conjunction with psychosocial interventions for both SUDs and mental illness is preferable and leads to better outcomes than either intervention alone. An important component of the treatment of patients with a COD is thus ensuring a recovery environment that is supportive of the various and individualized paths to recovery that many patients with CODs take. This includes ensuring that staff is receptive to the use of medications for both SUDs and mental health conditions when determined to be necessary and appropriate by counselors and clinicians practicing within their scope of practice.

In summary, the treatment of patients with a COD requires a comprehensive and flexible treatment approach, in addition to coordination with other systems of care.

Pregnant and Parenting Women Population

Substance use while pregnant can result in significant maternal, fetal, and neonatal morbidity. SUD providers offering services funded by DMC shall address specific treatment and recovery needs of pregnant and parenting women of up to 60 calendar days following birth⁷. Research indicates that targeted interventions to pregnant women with SUDs increases the incidence of prenatal visits, improves birth outcomes, and lowers overall health care costs for both mother and baby. The unique needs of pregnant and parenting women must be considered in the provision of services for this special population.

Motivational therapies are critical to the engagement and recovery process. While there is overlap between treatment approaches for the general population and pregnant and parenting women, ideal therapies for this special population incorporate treatment elements that are unique to this group. These include promoting bonding with the expected child, reproductive health planning, and targeted case management and care coordination to address the material and physical/mental health needs that accompany pregnancy. The initial assessment, Treatment Plan, and reassessments of progress need to take into account the varied needs related to the health and well-being of both woman and fetus/infant.

Federal priority guidelines for SUD treatment admission give preference to pregnant substance use users, pregnant injecting drug users, and any parenting female substance and injection drug users. However, a specific level of care is not prescribed and thus the appropriate setting and level of care for this population needs to be consistent with the ASAM criteria, with consideration of the ability to accommodate the physical stresses of pregnancy (e.g., climbing stairs, performing chores, bed rest when medically required, etc.) and the need for safety and support during this period. Level of care determinations need to be based on individualized and multidimensional ASAM assessments and may lead to placement recommendations in the residential or outpatient setting, depending on clinical need.

Staff working in settings that provide services for pregnant and parenting women need to be trained in proper procedures for accessing medical services related to prenatal care, labor and

⁷ California Department of Health Care Services (DHCS), Perinatal Practice Guidelines (PPG) FY 2018-2019

delivery, and therapeutic responses to the varied positive and negative outcomes of pregnancy. Services need to be provided in a non-judgmental, supportive, and open environment.

The use of MAT during pregnancy needs to include careful and individualized consideration of the potential impact of both treatment and lack of treatment on mother and baby. Though there is some risk in using medications during pregnancy, there is also known risk in the inadequate treatment of addiction during pregnancy, and this needs to be considered and discussed with patients. For pregnant women with opioid use disorders, MAT such as methadone and buprenorphine are the standard of care. In these instances, informed consent needs to be obtained, including discussions regarding Neonatal Abstinence Syndrome and what to expect at delivery. Opioid detoxification should also be reserved for selected women because of the high risk and potential consequences of relapse on both mother and baby. The risks and benefits of breastfeeding while patients are receiving medication-assisted treatments need to be weighed on an individual basis. Methadone and buprenorphine maintenance therapy are not contraindications to breastfeeding.

Given that women may be at increased risk of resuming substance use following delivery, treatment should not end with delivery. Post-delivery treatment services include, but are not limited to: support for parenting a newborn, education about breast feeding, integration with other children and family members, case management for practical needs such as legal assistance, equipment and clothing, coordination of physical and mental health services as needed, coping with the physical and psychosocial changes of the postpartum period, reproductive health planning, and encouragement of the continued pursuit of recovery goals.

Perinatal services must also be in accordance with the most recent version of the Perinatal Practice Guidelines released by DHCS.

Adolescent Patients

Adolescence represents an opportunity to influence risk factors that are still dynamic and not yet entrenched in their influence on development and addiction. Adolescent SUD treatment needs to be approached differently than adults because of differences in their stages of psychological, emotional, cognitive, physical, social, and moral development. Examples of these developmental issues include their newly formed independent living skills, the powerful influence of interactions between adolescent and family/peers, and the fact that a certain degree of limit-testing is a normal feature of adolescence.

These unique characteristics of the adolescent population are reflected in both clinical practices as well as in the ASAM criteria, as adolescents tend to require more intensive levels of care than their adult counterparts. As a result, the patient-to-counselor ratio for adolescent cases is ideally less than the ratio for adult cases to accommodate for this increased treatment intensity.

Due to the rapid progression of adolescent substance use, particular attention must be paid to streamlining the treatment admission process so that adolescent SUD needs are identified and addressed as soon as possible. Strategies to engage adolescents, hold their attention, channel their energy, and retain them in treatment are especially critical. Adolescent treatment needs to also address their increased rates of co-occurring disorders, highlighting the need to coordinate care with the mental health system, as clinically indicated.

Treatment Planning needs to begin with a comprehensive assessment based on the ASAM criteria. The assessment includes all the dimensions and biopsychosocial components of the complete adult assessment, the nuances of the adolescent experience, and their unique needs and developmental issues. Strengths and weaknesses need to be identified and adolescents need to be involved in setting their treatment objectives. Comprehensive adolescent assessments include information obtained from family, and when the appropriate releases are obtained, members of the community who are important to the adolescent patient, such as school counselors, peers, and mentors. The support of family members is important for an adolescent's recovery and research has shown improved outcomes for interventions that seek to strengthen family relationships by improving communication and improving family members' ability to support abstinence from drugs.

Optimal Treatment of the Adolescent Population

Generally, optimal treatment of the adolescent population requires greater amounts of external assistance and support compared to adults, and more intensive treatment and/or higher levels of care for a given degree of severity or functional impairment, when compared with adults.

Although most adolescents do not develop classic physical dependence, physical deterioration, or well-defined withdrawal symptoms as is common for adults who have longer durations of substance use, adolescents may be more susceptible to the functional impact of SUDs. For youth, casual substance use can quickly escalate to highly problematic abuse. Subsequently, adolescents often exhibit higher rates of co-occurring disorders, such as anxiety and depression, because of the negative impact that substance use has on normal adolescent social and psychological development.

During treatment of the adolescent population, every effort needs to be made to support the adolescent's larger life needs in order to maximize the likelihood of treatment success, for example by having flexible weekend and evening hours to accommodate continued engagement with school and appropriate social activities. These larger life issues may be related to medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues. Failing to address such needs simultaneously could sabotage the adolescent's treatment success.

Behavioral therapies, delivered by trained counselors and clinicians practicing within their scope of practice, need to be employed to help adolescent patients strengthen their motivation to change. Effective psychosocial interventions may provide incentives for abstinence, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with

constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

The use of MAT for adolescents is promising, but the current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. With the exception of methadone and buprenorphine, which can be prescribed in youth age 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber, there are currently no FDA-approved medications for the treatment of addictions in adolescents. As a result, the use of MAT for adolescents should be considered and used cautiously and only on a case-by-case basis when deemed clinically appropriate by a licensed prescriber. While most adolescents do not develop classic physical dependence or well-defined withdrawal symptoms as a result of shorter durations of substance use compared with adults, youth opioid addiction is an exception that at times may require MAT when clinically indicated, particularly for severe withdrawal symptoms.

The ASAM level of care criteria for adolescents are distinct from that of adults and are tailored to the particular needs of this population. In general, the ASAM criteria tends to place adolescents in more intensive levels of care than their adult counterparts.

Treatment services for adolescents occur in a setting that is clinically appropriate and comfortable for this population. The adolescent treatment environment should be physically separate from that of adult patients. Staff also need to be familiar and appropriately trained to address the developmental nuances of caring for this unique population.

Similar to other groups, treatment of the adolescent population is regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue into adulthood, with a gradual transition to adult SUD services.

Adolescent patients should be referred to a qualified adolescent/youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate level of care, as necessary. If the individual initially presents at a SUD treatment provider that does not offer the appropriate provisional level of care, that agency will identify alternate referral options and assist the individual in connecting with the selected agency, or the individual may elect to remain with the initial provider if clinically appropriate. All Medi-Cal eligible beneficiaries will be referred to, and/or served by, a DMC-certified agency for DMC-reimbursable services.

Young Adults

In this document, the term “young adult” refers to individuals between the ages of 18 – 20 and represents young people transitioning into adulthood, some of whom may have received services from the adolescent service system and may need continued services and supports from the adult system. Clinically, age range definitions should be viewed flexibly given the variable nature of chronological age and developmental maturity. This population presents unique service challenges because they are often too old for youth services but may not be ready for adult services. Young adults are simultaneously emerging into independence while still relying on the support of parents and caregivers. The mixture of adolescent and adult characteristics in the young adult population often requires a specialized approach due to issues of confidentiality, financial support, and shared living environments, among others.

Multidimensional assessments include determinations of the developmental stage of young adult populations to help inform treatment approaches and whether care modeled after adolescent approaches or adult approaches may be more appropriate. Strengths and weaknesses need to be identified and young adults need to be involved in Treatment Planning. When the appropriate authorizations are obtained, family should be involved in the information gathering and treatment process, when family involvement is clinically appropriate and determined to be beneficial.

Similar to youth, young adults typically have various life needs beyond their substance use treatment, and every effort need to be made to support these needs to increase the likelihood of positive outcomes. These larger life issues may be related to medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues.

Behavioral therapies and MAT, delivered by trained counselors and clinicians practicing within their scope of practice, should be employed depending on clinical need. As discussed in the Medication-Assisted Treatment section of this document, there are various medications used for addictions that have been FDA-approved for individuals over the age of 18 (and some over the age of 16) and need to be a treatment option available to young adults in conjunction with psychosocial interventions and as a component of a multifaceted treatment approach. Effective psychosocial interventions may provide incentives for abstinence, enhance motivation for change and recovery, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

Ideally, staff working with the young adult population would be familiar with and interested in working with the unique needs of this population. They should have experience in treating both the adolescent and adult populations in order to best blend necessary treatment approaches.

While the ASAM criteria does not specifically explore the specialized considerations of young adults, the ASAM criteria does note that an intermediate stage between adolescence and adulthood may become standard in the future, with accompanying treatment approaches that are individualized to address the unique assets, vulnerabilities, and needs of this group.

Optimal Treatment of the Young Adult Population

In general, the treatment needs of young adults will be more intensive than the typical adult, but less than the typical adolescent. This will require a blending of programs that currently exist for adolescents and adults, and ideally would occur within programs with specific expertise in treating this population. The approach toward caring for young adults needs to include a flexible mixture of treatment techniques depending on prior contacts with the treatment system and the unique needs of each clinical case.

For young adults who have previously been served in the youth system of care for their substance use and other health needs, every effort need to be made to coordinate care with their prior providers to determine the best treatment approach. Prior response to interventions should inform and guide future interventions, with the understanding that the approach toward treatment would be dynamic as young adults transition into adulthood.

Older Adults

Given the chronic nature of substance use disorders and the expanding population of older adults, it is increasingly important to modify treatment approaches to the unique needs of this population. In general, older adults include individuals over the age of 65, but this definition should be individualized based on clinical need. For example, some individuals younger than age 65 may have cognitive deficits, medical conditions, or social situations that necessitate the utilization of treatment approaches that are more typical for individuals of more advanced age.

Key differences between older and younger populations necessitate different approaches toward treatment. Due to altered metabolism and brain function, and the medical conditions that often accompany advanced age, the quantity and frequency of substance use in older adults may underestimate the functional impact in this population and create diagnostic challenges. In addition to the fact that many older adults are retired, limiting the sensitivity of using work or social impairment as a diagnostic indicator, a smaller amount of alcohol or substances may impact older adults more severely than younger counterparts. Health care providers also sometimes overlook substance use in this population, mistaking symptoms and indications of substance use for dementia, depression, or other problems common to older adults.

Social isolation, lack of transportation, and heightened levels of shame and guilt in this group may make accessing services for the older adult population more difficult than other age groups. As a result, older adults may be more likely to attempt to hide their substance use and less likely to seek professional help. Older adults are also more likely to be primary caregivers for a spouse who has greater needs than their own, which may limit their willingness to enter into treatment due to their caregiving responsibilities.

Research has demonstrated that age-specific assessment and treatment is associated with improved outcomes when compared with mixed-aged treatment. Assessments need to be age-specific and multidimensional, given the various physical and mental health needs, as well as social needs, of the older adult population. The treatment of older adults needs to be paced to the individual's physical and cognitive capabilities and limitations. The schedule of programs and expectations, and the overall timeframe for clinical progression and change is typically slower for older adults than other age groups. As such, treatment programs should be realistically designed to accommodate these anticipated differences.

Studies have generally indicated that cognitive-behavioral techniques are effective for older populations, particularly those that address negative emotional states that pose significant risk for relapse (e.g., self-management approaches for overcoming depression, grief, or loneliness). In general, confrontational therapy in this population has been shown to be less effective than in other age groups and should be avoided. Educational treatment approaches should be geared toward the specific needs of older adults (e.g., coping strategies for dealing with loneliness, general problem-solving). Older adults may absorb presented information better if they are given a clear statement of the goal and purpose of the session and an outline of the content to be covered. Repetition of educational information may also be helpful (e.g., simultaneous visual and audio).

Given that social isolation is a common problem in this population, group therapies and skill building around establishing social support networks are often beneficial, in addition to family therapy. According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse among Older Adults," consensus panel members recommend limiting involvement of family members or close associates to one or two members to avoid overwhelming or confusing older adults. Panel members also suggest that the involvement of grandchildren may lead to obstacles for open communication, as older adults may at times resent their problems being aired in the presence of younger relatives.

Medications used in older populations, including MAT, should be used with caution due to the physiological changes that occur with advanced age. Dosages of medications may need to be lowered, particularly if co-morbid medical conditions are involved. In cases where medications are used for withdrawal management, dosages for older populations should often be one-third to one-half the usual adult dosage. Concerns or questions regarding the safe use of medications in the older adult populations need to be directed toward appropriately trained medical professionals.

Optimal Treatment of the Older Adult Population

In general, panelists from SAMHSA recommend the following treatment approaches for the older adult population:

- Treat older people in age-specific settings, where feasible, ensuring appropriate pace and content of treatment.
- Create a culture of respect for older patients. Follow treatment approaches that are supportive, non-confrontational, and aim to build self-esteem.
- Take a broad, flexible, holistic approach to treatment that emphasizes age- and gender-specific psychological, social, and health problems. These approaches need to include building social support networks and coping skills dealing with depression, loneliness, and loss.
- Staff working with older adults need to be interested and experienced in working with this population.

Staff working with older adults should ideally have training in aging and geriatric issues. Staff should also have an interest in working with this population and the skills required to provide age-specific services for individuals of more advanced age. The best results are typically achieved when staff is experienced in dealing with the physical, psychological, social, and spiritual issues unique to older adults. Staff who interacts with older patients need to receive regular trainings on empirically demonstrated principles and techniques effective for older populations.

Criminal Justice Involved Patients

The criminal justice system includes accused or adjudicated who require various SUD services. Parole and probation status is not a barrier to SUD treatment services provided that the parolees and probationers meet the DMC eligibility verification and medical necessity criteria. For many people in need of alcohol and drug treatment, contact with the criminal justice system

is their first opportunity for treatment. Services can be provided through courts, probation or parole agencies, community-based or institutional settings, or in sex offender programs. In each of these situations, the individual is accountable to comply with a criminal justice sanction. Legal incentives to enter SUD treatment at times motivate individuals to pursue recovery, whereas for other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime.

Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach for the criminal justice population, particularly among offenders with a prolonged history of substance abuse and crime. However, strong empirical evidence over the past several decades has consistently shown that the criminal justice population can be effectively treated, and that SUD treatment can reduce crime.

Staff working with criminal justice populations need to be specifically trained in working with criminogenic risk, need, and responsivity (RNR), as well as SUDs and CODs. Staff also need to be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with probation and parole officers, judges, the court, and other legal entities involved in the patient's care.

The first step in providing SUD treatment to people under criminal justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to criminal justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.

In general, clinical approaches and the use of MAT need to be consistent with those utilized for individuals who are not involved with the criminal justice system, and a qualified counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements. Treatment interventions need to be based on a multidimensional assessment and individualized needs. However, working with the criminal justice population does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

For example, offenders from cultural minority groups may have unique cultural needs, women offenders are more likely to have been traumatized by physical and sexual abuse and to have concerns about their children, and many offenders have co-occurring substance use and mental health conditions that can complicate treatment. Strategies to engage offender populations are especially critical. Criminal justice patients often have problems dealing with anger and hostility, and experience the stigma of being criminals, along with accompanying guilt and shame. Other groups with specific needs include older adults, violent offenders, people with disabilities, and sex offenders.

Due to court mandates, classification policies and procedures, various security issues, and differences in available programming, one of the challenges of working with the criminal justice population is determining when the ASAM Criteria can be meaningfully applied. The ideal scenario is for the level of care setting to match the severity of illness and functional impairment, similar to the general population. However, there are instances in working with offenders that necessitate close collaboration with correctional staff to provide services that are clinically appropriate and that also align with correctional and supervision case planning and/or release conditions. When skillfully applied, the ASAM criteria can be used to access the full continuum of care in a clinically appropriate manner for the criminal justice population.

Optimal Treatment of the Criminal Justice Population

Effective clinical strategies for working with criminal justice patients may include interventions to address criminal thinking and provide basic problem-solving skills. Providers need to be capable of using evidence-based practices designed to address SUDs, mental health, and criminogenic needs. For example, motivational interviewing, cognitive behavioral therapy that focuses on both substance use and antisocial behaviors that lead to criminal recidivism, trauma-informed care, and contingency management therapies.

Similar to other groups, treatment of offenders needs to be regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue even after the legal issues for criminal justice patients are resolved.

Homeless Population

Homelessness is an issue that impacts many individuals with SUDs as a result of the socioeconomic decline that oftentimes accompanies addictions. Conservative estimates of the prevalence of substance use among homeless individuals are approximately 20-35 percent. Although homeless patients typically require more intense treatment and have greater and more varied needs than housed individuals, homeless patients pose significant challenges to the SUD treatment community because of the various structural, interpersonal, and biopsychosocial barriers they face in accessing care. Some of these obstacles include social isolation, distrust of authorities, lack of mobility and/or transportation, and multiplicity of needs.

Stable housing is often critical to attaining treatment goals and is an important component of necessary services. Services that link patients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet

the varied needs of homeless patients.

Optimal Treatment of Homeless Populations

Research supports the notion that effective programs for homeless patients address their substance use as well as their tangible needs (e.g., housing, employment, food, clothing, finances); are flexible and non-demanding; target the specific needs of subpopulations, such as gender, age, or diagnoses (e.g., COD/older adult populations); and provide longer-term, continuous interventions. As such, substance use in the homeless population cannot be treated apart from addressing the needs of the whole person in the context of their environment.

A continuum of comprehensive services is needed to address the various safety, health, social and material needs of homeless patients. Common examples include assistance with accessing food, clothing, shelter/housing, identification papers, financial assistance and entitlements, legal aid, medical and mental health care, dental care, job training, and employment services. These services may be provided within the SUD program itself or through linkages with existing community resources. Proactive outreach, addressing needs in a non-judgmental and non-threatening environment, and addressing the various identified needs early in treatment may help to better engage this population.

Psychosocial interventions and MAT for homeless patients need to mirror the approaches that are successfully used in other populations, with modifications to meet the unique needs of this population. Mobile outreach services are ideal, along with motivational enhancement interventions, in order to encourage continued treatment engagement. As a whole, the homeless population tends to be less responsive to confrontational approaches to treatment. Counselors and clinicians also need to be mindful of the physical and mental health needs of this population, given high rates of co-morbidity for many homeless individuals. Medications should be used when clinically indicated, with prescribing practices that take into consideration the environment in which these medications will be used and stored (for example, care is to be taken to ensure that

medications that require refrigeration are not prescribed when the patient has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of homeless persons tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

Successful counselors and clinicians who work with homeless patients tend to have a particular interest and comfort level in working with this challenging and rewarding population. Staff need to be experienced with the various aspects of care involved in working with homeless patients and need to be familiar with the resources available in the community so that appropriate referrals and linkages can be made in order to best address the varied needs of patients. Ideally, care teams work collaboratively and include interdisciplinary staff comprised of medical, mental health, substance use, and social service providers.

In general, treatment for homeless patients with SUDs is challenging, but successful outcomes can be achieved by prioritizing access to appropriate housing and providing comprehensive, well-integrated, patient-centered services with uniquely qualified staff.

Lesbian, Gay, Bisexual, Transgender, Questioning Population

Lesbian, gay, bisexual, transgender, questioning (LGBTQ) populations tend to experience higher rates of substance use than the general population. The stigma and discrimination of being a member of a marginalized community causes some LGBTQ individuals to cope with these additional stressors by using substances. Furthermore, research has also shown that once LGBTQ patients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ population faces in seeking treatment, and unique needs LGBTQ patients have that may not be addressed by SUD programs.

Although there are various protections in place that are intended to shield recovering substance abusers from many forms of discrimination, LGBTQ individuals are oftentimes not afforded the same protections. As a result of homophobia, heterosexism, and/or transphobia, some may find it difficult or uncomfortable to access treatment services and be afraid to speak openly about their sexual orientation or gender identity. Many LGBTQ patients may also internalize the effects of society's negative attitudes, which can result in feelings of sadness, doubt, confusion, and fear. Problems in traditional health care systems may lead to distrust of health care professionals, requiring extra sensitivity from SUD providers.

In many ways, psychosocial and pharmacologic interventions (e.g., MAT) geared toward LGBTQ patients are similar to those for other groups. An integrated biopsychosocial approach takes into account the various individualized needs of the patient, including the societal effects on the patient and their substance use. Unless SUD providers carefully explore each patient's individual situation and experiences, they may miss important aspects of the patient's life that may affect recovery (e.g., social scenes that may contribute to substance use, prior experiences being discriminated against, a history of antigay violence and hate crimes such as verbal and physical attacks, etc.).

As with any patient, substance use providers need to screen for physical and mental health conditions in LGBTQ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive screening and assessments can assist LGBTQ patients in accessing appropriate care for their physical and mental health concerns.

The methods of best practice outlined in the counseling competency model apply to all populations, particularly in working with LGBTQ patients. In this model, a counselor respects the patient's frame of reference; recognize the importance of cooperation and collaboration with the patient; maintain professional objectivity; recognize the need for flexibility and be willing to adjust strategies in accordance with patient characteristics; appreciate the role and power of a counselor as a group facilitator; appreciate the appropriate use of content and process therapeutic interventions; and be non-judgmental and respectfully accepting of the patient's cultural, behavioral, and value differences.

Family dynamics are also important in working with LGBTQ individuals and SUD providers need to be aware that family therapy may be difficult because of alienation owing to the patient's sexual/gender identity. However, inclusion of family in the treatment process may also result in more positive outcomes. Given common concerns regarding living environments (in terms of recovery and safety), social isolation, employment and finances, and ongoing issues related to homophobia and transphobia, particular attention needs to be paid to discharge planning.

Elements of treatment that promote successful treatment experiences for the LGBTQ patient include cultural sensitivity, an awareness of the impact of cultural victimization, and addressing issues of internalized shame and negative self-acceptance. Cognitive-behavioral therapies challenge internalized negative beliefs and promote emotional regulation, which can be helpful for relapse prevention. Motivational enhancement techniques may also encourage treatment engagement in this population.

Because each patient brings their unique history and background into treatment, furthering our understanding of individuals different from ourselves helps to ensure that patients are treated with respect and improve the likelihood of positive outcomes. At times, SUD treatment staff may be uninformed or insensitive to LGBTQ issues, may have preconceived biases toward LGBTQ patients, or may falsely believe that sexual identity/gender identity causes substance abuse or can be changed by therapy. In these cases, providers need to be aware of these

Important Considerations in the Treatment of the LGBTQ Population

There are some unique aspects of treating LGBTQ patients that providers need to be aware of. While group therapies should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ patients. Staff members need to ensure that LGBTQ patients are treated in a therapeutic manner and group rules should support an inclusive and welcoming culture within the group.

The LGBTQ patient is solely responsible for deciding whether to discuss issues relating to their sexual orientation and/or gender identity in mixed groups and not the other group members. Although providing individual services decreases the likelihood that heterosexism/homophobia/transphobia will become an issue in the group setting, there is also an opportunity for powerful healing experiences in the group setting when LGBTQ patients experience acceptance and support from non-LGBTQ peers.

beliefs in order to prevent them from becoming barriers to effective treatment of the LGBTQ patient. A substance abuse treatment program's commitment to promote sensitive care for LGBTQ patients can be included in its mission statement and administrative policies and procedures. Providing staff training and education are oftentimes valuable and include sexual orientation sensitivity training to promote better understanding of LGBTQ issues, trainings that assist staff in better understanding the needs of transgender individuals and the role that acknowledging gender identity plays in cultural competent treatment services, and other educational areas to ensure that quality care is provided. Providers who understand and are sensitive to the issues surrounding LGBTQ issues such as culture, homophobia, heterosexism, and sexual and gender identity can help LGBTQ patients feel comfortable and safe while they start their recovery journey.

Veterans

Important Considerations in Treating the Veteran Population

Given the higher likelihood of trauma, physical and behavioral health complications of the veteran population, SUD providers are encouraged to perform thorough assessments that encompass the full range of complications that may be present. For example, assessments may include questions concerning trauma, combat or war experiences, or injuries that may impact the patient's participation in SUD treatment. If the patient reports (or it is determined that) injuries exist that may impact treatment, the SUD treatment provider is encouraged to work with other providers (e.g., medical, mental health) to coordinate care, which is often particularly critical in this population.

Stigma is often an additional complicating issue. Although stigma exists around substance use, within the military stigma often also exists for seeking help for any health condition. Anger or personality disorders may also be present, further making treatment engagement difficult. In these instances, effectively engaging veterans and utilizing evidence-based techniques, such as motivational interviewing, will be critical to treatment success.

According to U.S. Census estimates, there are over 330,000 veterans who live in Los Angeles County. Although veterans share commonalities, their experiences are as varied and unique as their needs. Some veterans may have experienced combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb, or other physical injury, while others may have emotional scars. In particular, gender may also influence veteran experiences, as reports of women veterans who have experienced sexual harassment and/or physical and sexual trauma are becoming more common. As a result of the cumulative effects of these events and experiences, veterans and family members may develop SUDs and present to treatment with a unique set of needs and circumstances that must be addressed.

Under certain circumstances, veterans may be ineligible for Veteran's Administration (VA) benefits due to a dishonorable discharge or discharge "under other than honorable conditions," among other circumstances. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Regardless of the situation, SUD

treatment providers should work to ensure that the services provided address the varied and unique needs of individuals.

While substances of abuse vary, veterans may abuse sedating substances such as prescription drugs in efforts to address untreated/under-treated anxiety or other mental health conditions. Additionally, co-occurring physical health conditions and injury may increase rates of prescription drug and opioid abuse, including the use of heroin, and thus certain veterans may be at higher risk for fatal overdoses and may be appropriate candidates for MAT.

In summary, treatment providers may need additional training to fully understand the nuances of the veteran population and how their experiences impact their behaviors in order to adequately treat veterans and their families.

Population-Based Services by Funding Source – Adult Special Programs Defined

Special programs are those that have dedicated referral pathways and data tracking responsibilities from County partners that require additional documentation or procedures. These programs are typically comprised of special populations that warrant special attention during evaluation and treatment due to certain life circumstances or comorbid medical or psychosocial conditions.

Individuals must meet the conditions of the referral entity in addition to meeting medical necessity to access SUD treatment services under START-ODS. Contracted SUD treatment agencies providing services to these populations should utilize evidenced-based practices to assist individuals in developing awareness of the correlation between addiction and their involvement with the referring entity.

The SBAT will allow individuals, County partners, and other referral entities (e.g., SASH, CENS) to search for contracted SUD treatment agencies based on special parameters including those that serve the Criminal Justice, Perinatal, and Families with Children populations.

Los Angeles County Superior Court Referrals

In 1993, the Los Angeles County Drug Court Program was developed to divert drug offenders into SUD treatment services in lieu of incarceration. The model was founded on the notion that Representatives from the District Attorney, Public Defender, Probation, Judge, and contracted SUD treatment provider function as a multidisciplinary team. Each entity advocates for the public interest, patients' legal rights, responsible treatment progress, etc., to help develop, support, and continually motivate the patients' engagement in taking responsibility for their own treatment and continued recovery from their SUD.⁸ The model has grown to include dedicated Superior Court programs for women, individuals with co-occurring mental health, and those who have high risk to reoffend. Historically, SAPC funding and capacity have limited SUD drug court diversion to nine (9) dedicated courtrooms countywide.

(Substance Abuse and Crime Prevention Act of 2000), passed in November 2000 and implemented on July 1, 2001, amended drug sentencing laws where criminal defendants who

⁸ Adult Drug Court Best Practice Standards, Volume II, National Association of Drug Court Professionals).

were convicted of drug possession, use, transportation of drugs for personal use, or under the influence of controlled substance be placed in drug treatment as a condition of probation in lieu of incarceration. Clients who successfully completed drug treatment would be eligible to have their drug-related charges dropped. Funding for the Proposition 36 (now called Penal Code 1210) drug treatment program, which required defendants to pay out of pocket, ceased in September 2011. However, Proposition 36/Penal Code 1210 clients can now pay for drug treatment under Medi-Cal, My Health LA, or other County funding (e.g., AB 109). In these instances where Proposition 36/Penal Code 1210 clients are not eligible for any County funding assistance, SUD providers may serve these individuals and seek sliding scale reimbursement directly from the patient using the Client Fee Determination, as determined by the SUD provider.

In 2015, SAPC implemented screening services at the Community Collaborative Courts, developed by the Superior Court, to assist with its continued need to divert and link patients to SUD treatment. CENS staff co-located at participating Superior Court conducted these screenings.

Court Populations

Services are available to adults (ages 18+) who were arrested in and are residents of Los Angeles County and are referred from one of the following Superior Court programs:

- 1) **Client Engagement and Navigation Services Court Co-location for Proposition 47 Drug Cases (formerly known as Misdemeanor Diversion Treatment Track Project (MDTT))** - The primary goals of this project are to increase the percentage of defendants who engage in treatment following a plea to a Proposition 47 drug case, and to retain those defendants in treatment for a minimum of twelve weeks in order to earn dismissal and facilitate lasting behavioral change.
- 2) **Penal Code 1210 (PC 1210)** – Formerly known as Proposition 36, PC 1210 initially provided drug education, outpatient treatment, Narcotic Replacement Therapy, and/or residential treatment to adult offenders for individuals who meet the following criteria:
 - Arrested in and are residents of Los Angeles County
 - First or second time non-violent drug offenders who use, possess, or transport a small amount of illegal drugs for personal use.

These individuals are referred from the Courts pursuant to PC 1210.1 of the California Penal Code (PC) or PC 3063.1, have pled guilty, and have a suspended sentence contingent upon completion of a PC 1210 drug treatment program. With the implementation of START-ODS, SUD treatment is no longer restricted to outpatient treatment, Narcotic Replacement Therapy, and/or residential treatment. All LOCs are offered under the START-ODS Benefit Package.

- 3) **Los Angeles County Drug Courts** - Based on a national model, participating courts, law enforcement, Probation, and contracted SUD treatment providers work together to motivate and engage court-vetted, high risk/high needs defendants in long- term, court supervised treatment and recovery to become productive and law-abiding citizens in Los Angeles County. The Superior Court holds the discretion to dismiss all criminal charges upon successful completion of the SUD treatment and court supervision requirements.

- 4) **Sentence Offender Drug Court** - The Sentenced Offenders Drug Court program was established in 1998 as an intensive SUD treatment approach. This program includes a mandatory in-custody treatment approach for 90-days in county jail followed by community based, court supervised SUD residential and/or outpatient treatment services for convicted, non-violent felony offenders who are at high risk for return to incarceration.
- 5) **Community Collaborative Courts** – The Community Collaborative Courts are multi-disciplinary and resource intensive responses to addressing the needs of veterans, the chronically homeless, the mentally ill, victims of sex trafficking, transitional at-risk youth, and individuals with an SUD. The Community Collaborative Courts are built around the collaborative team approach involving the court (e.g. Public Defender, District Attorney, and Judge), Probation, and the Sheriff's Departments to engage defendants with health and social service resources in Los Angeles County.
- 6) **Los Angeles County Second Chance Women's Reentry Court** - The Second Chance Women's Reentry Court Program is a drug court-modeled program which provides female parolees and probationers who have re-offended and have chosen to participate in court-supervised, integrated SUD treatment (e.g., intensive residential treatment, outpatient treatment, and then recovery-support services) as an alternative to returning to incarceration.
- 7) **Co-Occurring Disorder Court (CODC)** – The CODC is a specialty referral court delivering collaborative services to court referred individuals with a co-occurring mental health and SUD. The CODC court program is founded on the drug court model of the court, Probation, mental health, and contracted SUD treatment providers, and law enforcement working as a multidisciplinary team to closely supervise and engage individuals in their treatment and well-being.

Screening and Referral Process

Should an arraignment court sentence a defendant to drug treatment through Penal Code 1210, pre- or post-plea diversion, or other City Attorney drug diversion program, the court will order the defendant to the court co-located CENS staff for an SUD screening (before leaving the courthouse).

Prior to doing so, the Judge will have explained that compliance with the treatment process is legally binding, and the consequences of failing to complete treatment (e.g. issuing of a bench warrant for their arrest and/or incarceration). If the CENS staff is not available, the individual will be referred to the SASH or directly to a SAPC contracted SUD treatment provider for screening and referral to treatment services.

CENS staff will administer a screening with the ASAM Triage Tool (ATT) for Young Adults (ages 18 – 20) and Adults (age 21+) and will explain the results with the defendant and the court, so that the defendant and court can make an informed decision on the patient's diversion into SUD treatment services. If all parties agree on the defendant's participation in treatment, the CENS staff will perform the following procedures unique to the Superior Court:

1. CENS staff will provide referral, linkage, and placement services to a SAPC contracted SUD treatment provider with expertise in serving the criminal justice population.
2. CENS staff will:

- Schedule an intake appointment with the agency within 48 hours of the assessment, and
 - Provide written instructions including contact information, treatment facility address, and date and time of the appointment to the defendant. This information will also be shared with the court.
3. CENS staff will verify treatment slot availability via the SBAT and contact the SAPC contracted SUD treatment provider about appointment availability via telephone.
 4. CENS staff will follow-up with the SAPC contracted SUD treatment provider and confirm that the referred individual attended the agreed upon appointment. If they did not attend the appointment, CENS staff will conduct follow-up actions to determine why the individual did not attend the treatment placement appointment. When appropriate, CENS staff will inform the court of the individual's failure-to-show. The court may take action accordingly, including issuing a bench warrant for the individual's arrest.

Treatment Requirements and Case Management

Court supervision remains at the discretion of the judge, however SUD treatment must be individualized and based on medical necessity. SUD treatment services for patients referred by the Superior Court may be a combination of various treatment service modalities, as described in the *Treatment Services* section.

Contracted SUD treatment providers delivering services to patients referred by the courts will be expected to inform the court of the patients' treatment progress (with informed consent), which may include the following:

- Assessment results and level of care
- Urinalysis screen results as requested by the court, if deemed clinically necessary and appropriate
- Development and attainment of Treatment Plan goals

Reporting of treatment activities will take place as ordered by the court and may occur in the following settings:

- **Pre-court staff meetings**
 - Team members consistently attend pre-court staff meetings to review participant progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court.
- **Status hearings**
 - Team members attend status hearings, with their patient(s) on a regular basis, as determined by the court team.
 - During the status hearings, team members contribute relevant information or recommendations when requested by the judge and/or court as necessary to improve outcomes or protect participants' legal interests.
- **Drug Court Management Information System**
 - The Drug Court Management Information System (DCMIS) is a web-based database application which selectively permits access to the data by a variety of system users, including Drug Court judges, court officers, project coordinators, treatment staff, and program managers.

- To guarantee confidentiality, all DCMIS users are registered and assigned specific data access privileges.

Treatment Program Procedures for Probation Referrals

In October 2011, DPH-SAPC and the Los Angeles County Probation Department (Probation) partnered to implement an assessment process and patient flow in response to the Public Safety Realignment Act or more commonly referred to as Assembly Bill (AB) 109. AB 109 called for the release of low-level felons from state prison to County Probation supervision, known as Post-release Supervised Persons (PSPs), and allowed new County offenders charged with offenses that are considered Non-violent, Non-serious, and Non-sexual (N3) to serve time in County jail versus state prison with condition of probation supervision upon release (known as N3 Splits). The passage of California Legislature Proposition 47 and Proposition 57 have also affected the number of county residents under Probation supervision.

SAPC contracted SUD treatment providers accepting referrals from the Probation Department are required to utilize the **Treatment, Court, Probation eXchange (TCPX) System**, which is a web-based data system application designed to support the operational and administrative requirements of Probation Supervision.

TCPX provides a “real-time” connectivity between contracted SUD treatment agencies, CENS, Probation, and the County.

Given that accurate records must be maintained to permit patient access to needed services, all treatment providers are required to accurately enter all patients’ data into the TCPX system daily.

Probation Populations

All individuals who are court ordered to report to the Probation Department for probation supervision will report to the area office ordered for intake. Probation will orient the patient regarding the requirements of supervision, explain the court ordered conditions of supervision, and make referrals to the appropriate linkages if services are recommended by the court. Under Probation, specialized caseloads are maintained to ensure compliance for certain populations including but not limited to:

- 1) **Assembly Bill (AB) 109:** Adult AB 109 male and female clients classified as PSPs, N3s, and N3 splits and have a history of criminal activity with the majority of them at high risk for recidivism.
- 2) **Co-Occurring Integrated Care Network (COIN):** The COIN program was designed to address the needs of adult AB 109 PSPs who have a co-occurring chronic substance use disorder (SUD) and severe and persistent mental illness. COIN provides integrated SUD and mental health treatment and follows the traditional Drug Court model. Treatment is for patients who are at high risk for relapse and are referred through the AB 109 Revocation Court.
- 3) **Proposition 47:** Also known as the Safe Neighborhoods and Schools Act was a referendum passed by voters in the State of California on November 4, 2014. It recategorized many nonviolent offenses, such as drug and property offenses, from misdemeanors, rather than felonies, as they had previously been categorized. These offenses include shoplifting, writing bad checks, and drug possession.

- 4) **Proposition 57:** Proposition 57 was a California ballot proposition, passed by voters on November 8, 2016. It allows the Parole Board to release nonviolent prisoners once they have served the full sentence for their primary criminal offense. Previously, prisoners were often required to serve extra time by a sentence enhancement, such as those for repeated offenders. In addition, Proposition 57 requires the Department of Corrections to develop uniform parole credits, which reward prisoners' good behavior with reduced sentences. Certain Proposition 57 clients may be required to be supervised by Probation under AB 109.
- 5) **Registered Sex Offenders:** Probationers assigned to this level of supervision are required to register with local law enforcement pursuant to Penal Code Section 290, regardless of whether the current offense is a sex offense or not. The client must report to the area office once a month for a face-to-face meeting with their probation officer. This population must participate in State mandated sex offender counseling while under supervision and as arranged by Probation. In accordance with State law, all high-risk sex offenders are placed on Global Positioning Satellite (GPS) monitoring for the duration of their felony probation supervision.⁹
- 6) **Gang Affiliations:** Clients assigned to this Probation caseload are determined to be active gang members or associates, may have specific orders from the court regarding participating in gang activity, or have a requirement to register with local law enforcement as a gang offender. These clients are seen once a month, face-to-face in the office and may be contacted in the field by members of the Probation Department Mobile Gang Unit.¹⁰

Referral Process

The probationer referral process begins when they arrive at their assigned Probation area office.

1. The probationer will meet with the Deputy Probation Officer (DPO) for screening and assessment and to receive specific instructions of probation supervision requirements. The DPO will screen the probationer using the Level of Services/Case Management Inventory, which measures the risk factors and needs of the client.
2. The DPO will refer the probationer to the CENS co-located at designated Probation Area Offices for an SUD screening if it is determined that the probationer has a history of a SUD and has frequent SUD-related contact with the criminal justice system.
3. The DPO will provide a TCPX referral form to the probationer with instructions to contact the designated CENS site within five (5) business days to schedule an appointment for an SUD screening
4. The DPO will enter the probationer data and referral information into the TCPX system for tracking purposes.

Assessment Process

The CENS shall perform the following procedures unique to Probation referrals during assessment and referral process:

1. Obtain from the client a copy of the Probation referral form when they arrive for the CENS screening.
2. Administer a screening with the ASAM Triage Tool (ATT) for Adults (age 21+) and initiate referral to a SAPC contracted SUD treatment SUD treatment provider, indicating the provisional level of treatment services needed based on the clinical screening.

⁹ <http://probation.lacounty.gov>

¹⁰ <http://probation.lacounty.gov>

3. The CENS will verify treatment slot availability via the SBAT and by contacting SUD treatment providers via telephone.
4. In the event that a client fails to show for the scheduled appointment, the CENS staff are responsible for contacting the client to facilitate the rescheduling of the assessment appointment. After rescheduling, the CENS should notify the client that if they miss the second appointment then the DPO will be notified.
5. Clients with revoked probation supervision will be screened by the co-located CENS at the Central Arraignment Revocation Court. The co-located Revocation Court CENS will conduct the clinical screening within two (2) days of notification from Probation or during court hours of operation.
6. CENS will update the TCPX system with the client's screening results, referral, and treatment information within 24 hours of the client's appointment.
7. CENS will provide the DPO with proof of screening (confirmation) or non-compliance (failure-to-show) via TCPX within 24 hours of scheduled appointment.
8. If the client has a residency restriction due to their criminal charge (e.g., sex-offender, arsonist, etc.) or requires special arrangements (e.g., wheelchair-bound, hearing impaired), the CENS should refer the client to an agency that is able to accommodate the client.
9. The CENS is responsible for following-up with the agency within 30 days of referral to ensure that special needs of the client are met.

Treatment Requirements and Case Management

Treatment agencies may not process an admission for a patient without proper documentation from the CENS. All documentation must be processed from the TCPX system. Only referrals printed from TCPX shall be accepted. The treatment provider will provide the patient and CENS with proof-of-enrollment or failure-to-show and update TCPX within 24 hours of enrollment.

Treatment services are administered based on medical necessity. SUD treatment services for patients referred by Probation may be a combination of various treatment service modalities as described in the *Treatment Services* section.

Status Reports

Each treatment agency is responsible for providing timely reports at the request of Probation. All treatment status/discharge reports will be prepared and maintained in TCPX. Probation is responsible for assessing the information in the report and determining if the patient is compliant with their conditions of Probation.

Status/Progress Reports are due as follows:

- Treatment Plan within 14 days of admission, completed in TCPX.
- Progress reporting, completed in TCPX at 30-day intervals for a treatment progress report, beginning from the date of admission, and/or as needed by the DPO.
- If the assigned DPO makes request, then a hardcopy of the status report may be delivered in a sealed envelope by the patient to the assigned DPO.

Compliance with Conditions of Probation

Los Angeles County law enforcement entities may conduct compliance checks to ensure the patient is adhering to conditions of probation. Treatment agencies shall obtain the proper consent to release information from the patient to allow law enforcement entities to conduct compliance checks. Compliance checks are limited to verification of enrollment and physical confirmation of the patient in treatment. Contracted SUD treatment agencies shall retain a copy of the form in the patient's file.

The DPO will work closely with the patient to encourage program compliance, support the patient in adhering to the Treatment Plan, and monitor, track, and supervise the patient to ensure public safety. Non-compliance with the case plan and/or individualized Treatment Plan could result in intermediate sanctions (e.g., house arrest, flash incarceration, or revocation process initiation).

Los Angeles County Sheriff's Referrals

Referral Process for Alternatives to Custody

The Los Angeles Sheriff's Department (LASD) utilizes Alternatives to Custody (ATC) to allow inmates to serve the remainder of their jail sentence in the community at a residential facility. All patients must receive clearance from the LASD Community-Based Alternatives to Custody Division for electronic monitoring in a therapeutic SUD residential treatment community in lieu of incarceration. ATC provides patients with a foundation to promote successful re-entry post incarceration, and under START-ODS patients will have access to additional services to assist with successful reintegration.

Patients participating in ATC will remain under the supervision of LASD for their residential treatment episode. Although participants must initially meet medical necessity to participate in the ATC program, they may remain in residential treatment for days 61-90 even if medical necessity is not met to prevent their return to custody. Treatment providers are expected to work with the justice system to transition patients to more appropriate levels of care (e.g. residential to outpatient with RBH) when an agreement can be met without jail time. Upon completion of their sentence, other treatment modalities are available to the patient on a voluntary basis if patient meets medical necessity.

Eligibility for the ATC shall be limited to those N3 patients referred through the LASD and meet the following general criteria:

1. Patients with a history of drug and/or alcohol usage and/or drug related charges for eligibility.
2. N3 classification.
3. No past violent, sexual, or arson charges.
4. 18 years or older.
5. No medical or psychiatric conditions that require medications prior to release.
6. Have a minimum of 90 to 120 days left on their sentence and no pending court dates. Patients that have less than 90 days may be considered for admission on a case-by-case basis.

Referral Process for Re-entry Populations

Substance Treatment and Re-entry Transition-Community (START-Community)

START-Community provides community-based residential treatment services for up to 90 days as an alternative to custody. Inmates must have 90 days left on their sentence with no pending court cases. In addition, they will remain under the supervision of the LASD, wearing GPS ankle monitors, for the duration of the residential treatment episode. Upon completion of their jail sentence, participants will have an option of continuing with additional treatment services, if deemed medically necessary. Continued participation would be voluntary.

To be considered for the START-Community program, eligible inmates are identified and assessed by LASD who will provide a referral list of potential inmates to the designated CENS staff. CENS staff will coordinate with LASD to conduct the SUD screening and make the appropriate referral into a community-based residential treatment facility.

Back on Track - Los Angeles (BOT-LA)

BOT-LA is an intensive recidivism pilot program housed at Pitchess Detention Facility that is funded by the California Department of Justice (DOJ) and jointly developed with LASD and the Department of Probation. In partnership with DOJ, Probation and LASD, co-located CENS staff will assist with community reintegration at the jail.

Community Re-entry and Resources Center (CRRC)

The CRRC is a hub station that operates as a one-stop shop for male inmates transitioning back to the community. The CENS provides the on-site SUD assessments to clients being released from the county jail or for Probation to refer AB 109 clients with potential need of SUD treatment.

The referral process for the CRRC begins when the client arrives at the kiosk located in the Inmate Reception Center Release Lobby. An LASD officer at the kiosk will conduct a preliminary screening and direct the inmate to the appropriate window. If the client is identified as a (PSP or N3/N3 Spilt, the officer will direct them to the Probation window. If appropriate, the on-site Probation Officer will initiate the referral for CENS assessment at the CRRC. If the client is a traditional-sentenced person and is seeking SUD services, the LASD officer will refer the client directly to the co-located CENS at the CRRC.

Assessment Process

LASD will notify CENS staff co-located at the Los Angeles County Jail and/or CRRC of potential clients for assessment. The CENS will:

1. Provide on-site screening assessment
2. Coordinate referrals to treatment
3. Coordinate support service referrals

ATC clients shall be referred to designated contracted SUD treatment providers with expertise in providing services to clients under electronic monitoring.

Note: Screening or assessing of post-release custody should be based on client's status **30 days prior to incarceration.**

Treatment Requirements and Case Management

Treatment services are administered based on medical necessity. With exception to residential treatment, treatment services for patients referred by LASD may be a combination of various treatment service modalities as described in the *Treatment Services* section.

Electronic Monitoring Requirements (ATC Referrals only)

Patients participating in ATC are required by LASD to wear GPS equipment at **all times**. Failure to adhere to this requirement will result in immediate return to custody. LASD contracts with a dedicated service provider for 24/7 technical support for GPS equipment. Should contracted SUD treatment agencies encounter any concerns with GPS equipment, they must contact the assigned Representative to report these concerns. Most common concerns reported include, but are not limited to:

- Battery life diminishing
- Patient wandering out of bounds
- Notification of patient being transported to off-site appointments

Compliance Check Procedures (ATC and BOT Referrals Only)

LASD will conduct periodic compliance checks for all patients that are receiving SUD treatment services and under electronic monitoring. Compliance checks are conducted at random and may occur in person or via telephone, and require a status report on the patient's progress, behavior and response to treatment.

In order for contracted SUD treatment agencies serving ATC patients to remain in compliance with LASD supervision requirements, agency staff must supervise ATC patients at all times. Any scheduled recreation activities, or off-site appointments need to be cleared with LASD two (2) weeks in advanced by contacting (213) 893-5345 for approval on a case-by-case basis. LASD will arrange GPS clearance for **approved** off-site activities. Patients are to be escorted by staff at all times while off-site.

ATC patients remain in-custody while participating in residential treatment therefore should a patient abscond from the residential treatment facility; contracted SUD treatment providers **MUST:**

- Contact the LASD GPS Service provider to report that the patient has absconded; and
- Contact LASD Inmate Reception Center at (213) 613-1729 to report patient has absconded.

Treatment Discharge Procedures for Criminal Justice Referrals– Successful or Unsuccessful

All discharge reports shall be prepared and developed in collaboration with supervising entity and should address discharge planning processes as described in the *Treatment Services* section.

Early Termination

Termination of any criminal justice referred patient can occur if the patient violates any facility rules, engages in violent behavior, utilizes alcohol and/or drugs, or makes threats to another participant. Contracted SUD treatment agencies shall notify the referring entity and document in the appropriate data tracking system (e.g., TCPX) the termination reason.

Termination can occur for the following reasons:

- One (1) or more positive drug tests
- Absconding, or willful violations of program requirements
- Participant poses a safety risk for self or others
- Participant opts out of project

Note: Termination of ATC patients will require the patient to be returned to jail to complete the remainder of their sentence.

Division of Adult Parole Operations (DAPO)

The adult parole population is supervised by the Division of Adult Parole Operations (DAPO), which consist of 110 parole units located throughout the State (information based on California Department of Corrections and Rehabilitation (CDCR) website as of May 21, 2018). DAPO's Division headquarters provides statewide oversight, while the Regional Administrators are responsible for the day to day operations related to the supervision of adult parolees. The field parole units supervise the adult offenders subject to State supervised parole, as well as those currently serving their sentences in an alternative custody program, and adult offenders released on medical parole.

Parolees can access SAPC's SUD System by calling the SASH or directly via the SBAT.

The parole population can access the County's START-ODS SUD treatment system of care through the SASH or direct-to-provider. In addition, SAPC contracted treatment providers are encouraged to participate in Parole and Community Team (PACT) Meetings, which. PACT Meetings are resource fairs for parolees the parole population offering information for various community resources (e.g., housing, legal counsel, etc.). At these PACT Meetings, SAPC contracted providers can educate and inform the parole population about their respective SUD treatment services and the services offered under County's START-ODS SUD treatment system of care.

Department of Public Social Services (DPSS) – California Work Opportunity and Responsibility to Kids (CalWORKs) Referrals

Referral Process

CalWORKs Welfare to Work (WtW) participants are screened by their GAIN Services Worker (GSW) during their GAIN Orientation and Vocational Assessment. Participants who screen positive for SUD, and those who self-declare a need for substance use services, will be referred for clinical assessment one of three ways:

1. Referral to the CENS area office nearest to the participant where the CENS will:
 - Schedule the screening appointment within three (3) business days after receiving the GSW GN 6006A referral;
 - Screen participant using the ASAM Triage Tool;
 - Secure intake appointment with an SUD treatment agency selected from the Family Services Provider Network list within three (3) business days of screening,

- Complete page two (2) of the GN 6006A and returns it to the GSW within five (5) business days of the screening; and
 - Forward a copy of the GN 6006A to the selected treatment provider.
2. Referral directly to a contracted SUD treatment agency;
 3. Referral to the SASH. The GSW will provide the client with the SASH number for screening and referral to treatment.

NOTE: Treatment agencies may also admit existing patients, who identify as having CalWORKs, without a formal GSW referral. This is called a “Reverse Referral”. When this occurs, the treatment agency must initiate notice to DPSS via a PA1923 form (see SAPC website), which states that the patient is in treatment and requests that their case be expedited to GAIN. The PA1923 form must be faxed or emailed via encrypted email, to the DPSS Centralized Unit (CU) for processing within ten (10) business days of completion of the PA1923 form.

Intake

Once the contracted SUD treatment agency receives the referral either directly from the GSW or the CENS, they are to:

- Schedule the assessment appointment within three (3) business days after receiving either the GN 6006A or GN 6006B referral;
- Conduct the full ASAM Continuum or SAPC Youth ASAM assessment;
- Complete page two (2), section B, of the GN 6006B; and
- Submit the GN 6006B to the GSW within five (5) business days of assessment to indicate if participant enrolled into treatment or if they failed to keep the appointment. If agency receives GN 6006A from CENS, agency is to file form in participant’s records as CENS already submitted a copy to the DPSS GSW.

The patient shall be admitted to treatment according to appropriate level of care and/or patient’s preferences. If the patient has to transfer to a different agency, a copy of the GN 6006B will be faxed to the GSW to notify them of the patient’s new treatment location. A copy of the GN 6006B must also be forwarded to the new treatment agency.

Treatment Requirements and Case Management

Treatment services are administered based on the medical necessity. Services may be a combination of various treatment service modalities as described in the *Treatment Services* section. SUD treatment services for CalWORKs participants include: outpatient, residential, withdrawal management (WM), also known as detoxification, recovery bridge housing, and recovery support services.

Status Reports

Contracted SUD treatment agencies are required to communicate the status of the patient’s progress and treatment/services to DPSS using the appropriate forms noted below:

- Complete GN 6006B, page two (2) within five (5) business days of service enrollment, to report date services began, (or failure to appear for services), expected duration of hours per week and, if less than 32-35 hours per week, whether the number of hours is considered full-time by the service provider.

- Complete GN 6008, Service Provider Progress Report, every 90 days, or as required, to indicate whether the participant is complying with program requirements and maintaining satisfactory progress, has successfully completed treatment, or has dropped out of treatment.
- After treatment for 90 days, complete the CW 61, Authorization to Release Medical Information (see the SAPC website). This form is used to evaluate a participant's ability to participate in a work/training program. The clinician completing the form will determine the length of time the person should be exempt from work requirement. At the end of that timeframe, the GSW will contact the participant to determine if they are able to participate in a work-related activity.
- Complete GN 6007B, Enrollment Termination Notice, within three (3) business days of termination to report if the participant has successfully completed treatment services, or treatment services were terminated and the reason for termination.
- Complete GN 6007A, Notification of Change from Service Provider, within five (5) business days of a service change. This will include changes in levels of care, start date, treatment hours, and other service information.
- Contracted SUD treatment agencies must retain copies of all documentation and communications with DPSS, in the patient's chart, including: the PA 1923, GN 6006A, GN 6006B, GN 6007, GN 6008, confirmation of faxing, and any letters/ correspondence to and from DPSS regarding the patient. This includes any written notice of eligibility/acceptance provided by the Centralized PA 1923 unit. Agencies must obtain and keep on file a Provider Notification Letter for patients entering treatment through the PA 1923.

Department of Public Social Services – General Relief Referrals

Referral Process

All adult General Relief (GR) applicants/clients, as a condition of eligibility, are required to undergo a pre-screening interview for a SUD. If there is a reasonable suspicion of a SUD, the GR applicants/clients must be referred to the DPSS Mandatory Substance Use Disorder Recovery Program (MSUDRP). Clients with a positive SUD pre-screen are referred 1) to the CENS area office nearest to the participant; 2) directly to a contracted SUD treatment agency; or 3) SASH for a clinical screening and/or assessment.

Treatment Requirements and Case Management

Treatment services are administered based on medical necessity. Services may be a combination of various treatment service modalities as described in the *Treatment Services* section.

The Treatment Progress Report (Form ABP 132) is generated by LRS and mailed directly to receiving contracted SUD treatment agency every 60 days for completion, and returned to DPSS, who monitors the individual's participation. LRS resets this date to generate a new Treatment Provider Progress Report form.

Contracted SUD treatment agencies are required to notify DPSS of all changes in participant's status within five (5) days of the actual change including:

- Transfers to other sites or treatment modalities,
- Drop outs, completions

Contracted SUD treatment agencies are required to notify DPSS within three (3) days, of changes in the number of hours participants are in treatment using the Report of Changes form. These changes should correspond to changes in the participant's Treatment Plan. Treatment Extensions are initiated when agencies determine the patients' need for treatment beyond the initial six (6) months, based on medical necessity.

If a treatment extension is needed, the contracted SUD treatment will submit a reauthorization request to the SAPC Utilization Management (UM) Unit that evaluates and approves/denies the request. The contracted SUD treatment agency will forward the form to DPSS for final approval/denial who then updates LRS. It is up to DPSS to notify and send copy of extension status back to the contracted SUD treatment.

Department of Children and Family Services (DCFS) – Promoting Safe and Stable Families Time Limited Family Reunification (PSSF-TLFR) Referrals

Referral Process

In order to be eligible for SUD treatment services under PSSF-TLFR, any adult parent or caregiver must have an open case with DCFS with at least one (1) child placed in out of home care for 15 months or less. As part of their family reunification plan, parents and/or caregivers must enter alcohol and other drug treatment services during these 15 months. The DCFS Children's Social Worker (CSW) identifies parents/caregivers who may need SUD treatment services and verifies their eligibility through the DCFS PSSF-TLFR Program Manager. Once eligibility is verified, the DCFS CSW or the DCFS PSSF-TLFR Program Manager will refer their participants for a clinical assessment, using the DCFS 6006A, in the following way:

- Direct to a contracted SUD treatment agency nearest to the patient, where the treatment agency will:
- Schedule an ASAM assessment appointment within three (3) business days of receipt of the DCFS 6006A from the TLFR Manager;
- Make best efforts to complete the ASAM Continuum assessment within five (5) business days of appointment;
- Complete page two (2), sections B and C of the DCFS 6006B and faxes form to the DCFS CSW within 24 hours of completing assessment;
- Notify CSW of any appointments the parent missed within 48 hours of the patient's missed appointment date.

The contracted SUD treatment agency will follow up on DCFS participants who fail to keep their initial assessment appointment and reschedule a missed appointment once. PSSF-TLFR participants who fail to keep the second appointment must contact their CSW.

Treatment Requirements and Case Management

Treatment services are administered based on the medical necessity. Services may be a combination of various treatment service modalities as described in the *Treatment Services* section.

Contracted SUD treatment agencies are advised that in serving these patients, family counseling sessions should be an integral part of the Treatment Planning and services. Additionally, the treatment agency will participate in the DCFS Child Family Team (CFT) meetings regarding patients in this program.

Status Reports

The contracted SUD treatment agency will notify CSW of the patient's progress in treatment and any changes in their program status within three (3) business days of the changes. Changes may include patient who successfully complete treatment, those who drop out or are terminated from the program, and those who are being transferred to another modality.

The contracted SUD treatment agency will be responsible for:

- Providing the CSW with an initial Treatment Plan within five (5) business days after the participant enters a treatment program;
- Completing and submitting the DCFS 6008 Progress Report every 90 days after the initial Treatment Plan indicating dates of service, compliance with treatment, and any changes in level of treatment;
- Completing and submitting the DCFS 6007B Enrollment Termination Notice summary within three (3) business days after the participant is discharged or leaves the program.

The contracted SUD treatment agency must maintain copies of all documents and communications with DCFS in the patient's chart including: copies of the DCFS forms completed and signed by all parties, faxing confirmations, and any letters/correspondence to and from DCFS regarding the participant.

Department of Children and Family Services – Family Dependency Drug Court (FDDC) Referrals

Referral Process

In order for adult male/female parents, age 18 and older, to be eligible for treatment services under the FDDC program, parents must have active cases with the Department of Children and Family Services (DCFS) and the Juvenile Dependency Court. While efforts are being made to foster family reunification, parents enter the program on a voluntary basis and are under court supervision for the duration of treatment.

Candidates for the program are identified either by the DCFS office located nearest the parent, dependency attorneys for parents and children, County Counsel and/or judicial officers. Referrals into the FDDC program are initiated by the assigned DCFS FDDC Children's Social Worker (CSW). The CSW will refer the participant to one of the dedicated DPH contracted FDDC SUD treatment agencies closest to the participant's location.

The FDDC SUD treatment agency will conduct a full ASAM assessment for all participants referred into the program. The FDDC SUD treatment agency will notify the CSW of the assessment results, via fax, within 48 hours of completing the assessment.

If the DCFS CSW determines the participant is suitable for the FDDC program, the CSW makes a recommendation to the court to admit the parent into the FDDC program for a trial period of no more than two (2) weeks. During the parent's admission into treatment, the FDDC SUD treatment provider will ensure that the patient has completed the following:

- Orientation/overview of the FDDC program;
- The ASAM Continuum assessment; and
- Initial Treatment Plan.

Treatment Requirements and Case Management

Treatment services are administered based on medical necessity. Services may be a combination of various treatment service modalities as described in the *Treatment Services* section.

Contracted FDDC SUD treatment agencies are advised that in serving these patients, family counseling sessions should be an integral part of the Treatment Planning and services.

Once accepted into the FDDC program, the CSW:

- Contacts the contracted SUD treatment agency that completed the initial screening/assessment and schedules an intake appointment for the patient.
- Completes sections A and B of the FDDC referral form and faxes it to the selected contracted SUD treatment provider.

Status Reports

Contracted FDDC SUD treatment agencies serving FDDC patients are required to:

- Complete section C of the FDDC referral form, ensuring patient has completed section D, and return it via fax to the FDDC CSW within five (5) business days of the intake appointment.
- The contracted SUD treatment agency must submit an initial report to the DCFS CSW within five (5) business days of the treatment admission.
- Contracted SUD treatment agencies must submit a progress report to the DCFS CSW within five (5) business days prior to the participant's scheduled Court appearance.
- Contracted SUD treatment agencies must submit a progress report to the DCFS CSW immediately upon discharge (expected or unplanned).
- Submit progress reports for each court hearing that reflects patient progress since the last court hearing, pertaining only to SUD treatment services. Recommendations and/or comments on visitation rights are not permitted.

Treatment Completion/Reunification

1. Contracted SUD treatment agencies must work closely with the DCFS CSW on family reunifications. Discharge planning should begin shortly after the patient enters treatment and should focus on aftercare preparation.
2. Within five (5) working days of program completion, the treatment provider shall enter the information on a progress report to confirm completion and notify DCFS and/or court of patient discharge. A copy of the completion report will be delivered in a sealed

envelope by the patient to the CSW and the court.

3. When patients are terminated from treatment due to non-compliance, the contracted SUD treatment provider shall forward a termination report to the CSW and the court within five (5) business days of program termination.
4. Graduations are conducted to acknowledge the completion of the FDDC program and may take place at a later date designated by the contracted SUD treatment provider and/or court. Graduation marks the end of SUD treatment episode.

Pregnant and Parenting Women (PPW)

Referral Process

Perinatal clients who self-identify or are identified by a County department (e.g. DCFS) are referred to the appropriate level of care by the CENS, SASH, or may present directly at a SUD agency. Patients should be directed to a Pregnant and Parenting Women (PPW) Service provider to ensure that patients are receiving all services to which they are entitled. Only designated PPW agencies are allowed to bill for perinatal services.

Perinatal Target Populations

The Perinatal Practice Guidelines (PPG) provides guidance on perinatal requirements in accordance with Drug Medi-Cal (DMC), and the Substance Abuse Prevention and Treatment Block Grant (SABG) Perinatal Set-Aside from the Substance Abuse and Mental Health Services Administration (SAMHSA). The SABG requires specified funds to be used for perinatal clients and are governed by 45 CFR, Part 96, Subpart L; DMC funds are governed by Title 22 of the California Code of Regulations.

In accordance with the SABG requirements, all PPW Service Providers must treat the family as a unit and admit both women and their children into treatment services, if appropriate. PPW Service Providers must service the following individuals with a SUD: pregnant women, women with dependent children, women attempting to regain custody of their children, postpartum women and their children, or women with substance exposed infants. PPW Service Providers shall address specific treatment and recovery needs of pregnant and parenting women of up-to 60 days postpartum.

PPW Service Providers, who are contracted to provide Residential or Recovery Bridge Housing (RBH) will be able to be reimbursed for the cost of room and board, and/or for the bed day rate for RBH for children (0-16) who accompany or have overnight visits (not to exceed 7 days) with the parent in these settings while in treatment. Services will be covered using SAPT-BG Perinatal Set-Aside funds as applicable or other non-DMC funds as needed, to account for PPG required services.

Per the Perinatal Practice Guidelines (PPG), PPG Perinatal Eligibility

- Pregnant women
- Women with dependent children
- Women attempting to regain custody of their children
- Postpartum women and their children
- Women with substance exposed infants

PPG Admission Priority

SUD agencies serving PPW shall provide preference to pregnant women following this priority admission order:

- Pregnant injection drug users
- Pregnant substance users
- Injection drug users
- All others

Treatment Requirements and Case Management for Perinatal Populations

Per the PPG, treatment agencies that serve PPW are to provide or make arrangements for the following treatments services:

- **Primary Medical Care** – Including a referral for prenatal care to pregnant and parenting women receiving SUD treatment services (NOTE: Childcare services must be provided during this specific treatment)
- **Primary Pediatric Care** – Including immunization for the children while the pregnant and parenting women are receiving SUD treatment
- **Gender-Specific Services** – Including relationships, sexual and physical abuse, and parenting
- **Therapeutic Interventions for Children** – Treatment services for the children of the women receiving SUD treatment services should address the child's developmental needs, sexual abuse, physical abuse, and neglect
- **Case Management** – Includes the arrangement, coordination and monitoring of services; primary medical care, gender-specific treatment, and therapeutic interventions for adults.
- **Child Case Management** – Includes the arrangement, coordination, and monitoring of services; primary pediatric care, gender-specific treatment, and therapeutic interventions for children.
- **Perinatal Transportation** – Must provide/arrange transportation for pregnant or parenting women for primary medical care, primary pediatric care, gender specific treatment, and therapeutic services for children.
- **Childcare** – Child care must meet applicable standards of State and local law for licensed and/or licensed-exempt child care, as defined in Title 22, Division 12, Chapter 1. SAPC will reimburse for the following types of childcare for children ages 0-14 years:
 - **Cooperative (Co-op) Child Care** – Licensed-exempt cooperative childcare is delivered while the mother receives SUD treatment services. Co-op childcare involves one woman watching the children of her fellow group members while they participate in treatment. The patient/care-giver watching the children should rotate so that each woman gets the opportunity to participate in treatment.
 - Staff to caregiver to child ratios are one (1) staff and one (1) caregiver to 12 children.
 - **Licensed-Like Child Care**
 - Staff to caregiver to child ratios are as follows:
 - Infants (0 to 18 mo.): one (1) staff to three (3) children.
 - Toddlers (18 to 36 mo.): one (1) staff to four (4) children.
 - Preschool Age (36 to 60 mo.): one (1) staff to eight (8) children.
 - School Age (5 to 14 years): one (1) staff to fourteen (14) children.

For more information, on expanded services for PPW, please see the START-ODS Perinatal Services Bulletin.

Drug Medi-Cal Perinatal Eligibility

- Physician shall determine whether SUD services are medically necessary or shall document approval of diagnosis that is performed by therapist, physician assistant or nurse practitioner by signing and dating the treatment plan.
- Medical documentation to substantiate pregnancy and last day of pregnancy must be in patient record.

Pregnant and up to 60 days postpartum. A pregnant woman who was eligible for and received Medi-Cal services during the last month of pregnancy shall continue to be eligible for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy.

Drug Medi-Cal Perinatal Eligibility

- Physician shall determine whether SUD services are medically necessary or shall document approval of diagnosis that is performed by therapist, physician assistant, or nurse practitioner by signing and dating the treatment plan
- Medical documentation to substantiate pregnancy and last day of pregnancy must be in the patient record
- Pregnant and up to 60 days postpartum. Eligibility (based on pregnancy) ends on the last day of the month in which the 60th day occurs (sources: Title 22, Section 51303; 22 CCR § 50260))))).

Mother/Child Habilitative Services

Per Title 22, Drug Medi-Cal Perinatal programs are to provide mother/child habilitative services. These services focus on the development of parenting skills and training in child development, and the coordination of ancillary services. Services include:

- Education to reduce the harmful effects of alcohol and other drugs on the mother and fetus, or the mother and infant.
- Therapeutic interventions addressing issues such as relationships, sexual and physical abuse, and parenting.

Additional Perinatal Services

In addition to providing the expected services, treatment agencies providing PPW services should incorporate the following into PPW treatment services:

- Promote bonding with the expected child;
- Reproductive counseling;
- Care coordination to address the material and physical/mental health needs that accompany pregnancy;
- Support for parenting a newborn, education about breast feeding, and integration with other children and family members;
- Case management for practical needs such as legal assistance, equipment and clothing, coordination of physical and mental health services as needed, coping with the physical

and psychosocial changes of the postpartum period, family planning, and encouragement of the continued pursuit of recovery goals.

For more information on the services that are required to be provided to the PPW population, see the Perinatal Practice Guidelines.

Discharge

Begin discharge planning shortly after the patient enters treatment services. This planning should include family planning, and encouragement of the continued pursuit of recovery goals, education planning and reunification planning (if applicable).

Homeless Services

Because homeless patients have greater and more varied needs than housed individuals, they typically require more intense treatment that addresses the needs of the whole person in the context of their environment. A full continuum of comprehensive services is necessary to treat the whole patient and fully address their needs. As part of Los Angeles County's agenda to combat homelessness and effectively serve the homeless, special funding through Measure H quarter-cent sales tax is allocated to support Recovery Bridge Housing for homeless patients who are exiting from institutions such as jails, prisons, other correctional facilities, hospitals, urgent care centers, SUD residential treatment centers, mental health treatment facilities, and foster care and probations camps for young adults aging out of these settings (**See Recovery Bridge Housing section for full benefit details**). Measure H also supports SUD screening and referral services at several permanent supportive housing sites countywide (**See Client Engagement and Navigation Services section for full benefit details**). However, through general Drug Medi-Cal funding, case management plays a critical role in addressing the homeless patients' unique needs (**See Case Management section for full benefit details**). The following services may be provided within the SUD program itself or through linkages with existing community resources.

Target Population

All single adults, youth, and families who meet the homeless or chronic homeless definition set by the U.S. Department of Housing and Urban Development (HUD), Los Angeles County agencies, and other local housing organizations.

Intake Process

A patient who identifies as homeless during the ASAM Continuum or SAPC Youth ASAM assessment should be referred to the SUD counselor to determine the patient's housing and service needs.

Assessment

The trained SUD counselor from a provider with access to the Homeless Management Information System (HMIS) will administer the Coordinated Entry System (CES) Survey Packet including the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) for homeless adults, and the Next Step Tool for youth and young adults; enter or update the homeless patients' information into HMIS; and start coordinating with the CES agency for the patients' housing within fourteen (14) calendar days of first treatment service or intake appointment. Treatment providers that have not been trained on the CES adult and youth tools

and have not received access to HMIS will need to refer the homeless patients directly to the CES agency within the same Special Planning Area, likewise within fourteen (14) calendar days of first service or intake appointment.

For patients who are homeless with their families, the SUD case manager will call 211 or refer them to any of the CES for Families agencies countywide to schedule a housing screening appointment. Depending on the availability of resources, adult and young adult patients may be offered DPH-SAPC's Recovery Bridge Housing benefit if they prefer a temporary abstinence-focused environment prior to securing more permanent housing.

Treatment

For providers that are trained and have the capacity to deliver housing services, the SUD case manager will coordinate with the CES Housing Navigator to ensure that all necessary documents and forms have been uploaded into the HMIS and that the patient is Match Ready (e.g., necessary documentation is collected and entered into HMIS), and eligible for permanent housing vacancies listed in the CES. The SUD case manager will also assist the patient in completing the necessary application forms.

Discharge

The CES Housing Navigator will notify the SUD case manager when a housing resource has been identified, and the corresponding Housing Provider has been notified of a match. The SUD case manager will coordinate the appointments between the Housing Provider and the patient, verifying eligibility information, and assisting the patient with the housing application process. The CES Housing Navigator will assist the SUD case manager with move-in resources (e.g., security deposits, furnishings, etc.) for the patient. The SUD case manager will link the patient to the appropriate supportive services for securing and maintaining appropriate housing, including income/benefits/employment and transportation.

Population-Based Services by Funding Source – Youth

Programs described below require the active participation of the Youth SUD treatment provider and the referral source. Activities may include case management services (e.g. providing status reports on patient's progress to judge, probation officer, or social worker), participating in case conferences, and developing and implementing a Treatment Plan in collaboration with the referring staff.

Juvenile Justice Crime Prevention Act Program

The Juvenile Justice Crime Prevention Act (JJCPA) Program is a collaborative project between SAPC and Probation. The goal of the treatment program is to:

1. Provide youth with skills to resist continued substance use and the associated negative behaviors
2. Demonstrate reductions in subsequent arrests, incarceration, and probation violations
3. Increase completion of probation, restitution, and community service requirements

Target Population

JJCPA services are for at-risk youth and probation involved youth.

Referral Process

- Youth are typically referred when conditions of probation require SUD treatment and/or prior to exiting Juvenile Probation Camps (for youth with a history of SUD).
- The Probation Department's Prospective Authorization and Utilization Review (PAUR) Unit makes and/or approves all JJCPA referrals to Youth SUD providers. This includes referrals by school-based and other Probation Officers.

Reporting Requirements and Procedures

- **Reporting to Probation:** A Community Based Organization (CBO) Note must be entered into Probation's web-based reporting system (<https://probjjcpap.lacounty.gov/cbo>) for each JJCPA referral, regardless of admission status, and at least once every 30 days for youth admitted into treatment. For all admissions, the "Enter Service Data" screen in Probation's web-based reporting system must be completed monthly and updated as necessary.
- **Reporting to SAPC:** The contracted SUD treatment provider must electronically submit a Program Participant Report that lists all new referrals, youth in treatment, and closed cases, to SAPC by the tenth (10th) of the month following the reporting month. All JJCPA admissions must also be entered in CalOMS/LACPRS.
Data reported on the Program Participant Report must be consistent with information reported in LACPRS and the Probation Department's web-based system.

Staffing and Fingerprint Clearance

DPH-SAPC and Probation shall be responsible for ensuring ongoing compliance of background and security investigations applicable to each department's contracts and contract employees.

Crossover (241.1) Youth

This is a collaborative project involving SAPC, the Los Angeles County Juvenile Courts, DCFS, Probation, DMH, and the Chief Executive Office (CEO), aimed at improving access to quality- and outcome-focused SUD treatment services for crossover youth.

Target Population

Crossover youth are minors under the supervision of both the dependency (indicated by involvement with DCFS) and delinquency (indicated by involvement with Probation) systems. The youth become involved in one system and subsequently become involved in the other system; hence, the terminology, that a youth has "crossed over" and is under "dual supervision".

Court Determination Process

- For dependent youth charged with a criminal offense, DCFS and Probation are required to prepare a joint assessment and recommend to the Delinquency Court which system would best serve the interests of the youth and the community.
- A Predisposition Multi-Disciplinary Team (MDT) that includes the DCFS clinical social worker (CSW), Deputy Probation Officer (DPO), DMH psychiatric social worker (PSW),

and an education consultant, meets to review available records and make a recommendation to the Delinquency Court about the legal status of and appropriate services for the youth.

- The Delinquency Court holds a disposition hearing where it adjudicates the delinquency arrest petition and, if sustained, determines whether the youth will continue to be a ward of the dependency system, delinquency system or both (dual-status). Based on this decision, the SUD provider will know if the DCFS clinical social worker or the DPO will be the lead in coordinating SUD treatment services.
- After the disposition hearing, the Post-Disposition MDT meets to finalize the case plan and establish linkages with the providers. At this point, the Youth SUD provider becomes involved, engages the youth, and arranges for SUD screening and treatment services, if needed.

SUD Referral Process

- If the Pre-Disposition MDT recommends, and/or subsequent court orders indicate, a need for SUD treatment services, the crossover youth is referred to an approved Youth SUD treatment provider for an assessment.
- If court orders also indicate a need for mental health services, DMH will coordinate any required substance abuse services.
- The assigned DCFS 241.1 (Crossover Youth) Liaison contacts an approved Youth SUD treatment provider to attend Post-Disposition MDT meetings for any youth requiring SUD services who does not also require mental health services. The youth is referred to the selected, approved Youth SUD treatment provider that is closest to the youth's current residence.

SUD Assessment, Admission and Discharge

The Youth SUD Treatment Provider will assess and admit the youth in accordance with SAPC contract requirements and the agency's policies and procedures.

- Complete the assessment to determine treatment appropriateness
- Admit the youth for services according to agency policies and procedures and complete the CalOMS/LACPRS admission screen.
- Ensure that all releases of information are in place to allow effective communication on treatment progress with CSWs and DPOs directly involved with the youth's case.
- Provide treatment services in accordance with the youth's level of need and as outlined in the Treatment Plan.
- Engage the family/caregivers in services as clinically appropriate, including parent education courses and family sessions.
- Submit progress notes/miscellaneous notes as required and based on the type of referral.
- Limit the summary to general information on whether the youth is or is not progressing on treatment goals.
- Exclude drug tests unless specifically requested and agreed by all parties.
- Submit DMC claims reimbursement before utilizing alternate contract resources.
- Discharge the youth from services according to agency policy and procedures and complete the CalOMS/LACPRS discharge screen.

Data Reports and Outcome Tracking

- CalOMS/LACPRS: Enter each youth referred under this project, into the CalOMS/LACPRS system.
- Monthly Data Report: Each participating Youth SUD Treatment Provider should submit a monthly report to SAPC by the 10th of the next month.
- Outcomes Collected: System is currently under development, to be administered by DCFS with data analysis to be done by Cal State LA.

Title IV-E Youth Project

Title IV-E Youth Project is aimed at providing dedicated outpatient SUD treatment slots for probation involved youth at risk of entering foster care and youth transitioning from group homes to community placement in Service Planning Areas (SPA) 4, 6, 7, and 8.

Target Population

This project targets individuals who are at imminent risk of removal from their home or are transitioning from a group home to community placement in SPAs 4, 6, 7 and 8.

Referral Process

- DPO submits referral form to Probation Department - Placement Services Bureau's Prospective Authorization and Utilization Review (PAUR) Unit.
- The PAUR refers the youth to the Youth SUD provider closest to the youth's home.
- The PAUR or designee provides the Youth SUD provider with the date of the discharge MDT meeting.
- The Youth SUD provider attends the discharge MDT meeting to screen the youth to ensure appropriateness of SUD services and, if accepted, to better guarantee a smooth transition to outpatient services.
- The Youth SUD provider determines and provides the appropriate level of care or refers youth to the appropriate agency.
- The appropriate Youth SUD provider delivers SUD services to the youth within five (5) business days of release from a group home. Transition services can begin prior to group home discharge as agreed and if in the best interest of the youth.
- For youth who are at risk for out-of-home placement, the Youth SUD provider screens the youth and, if appropriate, admits the youth within five (5) business days of discharge.
- The Youth SUD provider assures availability of treatment slots and will only maintain a wait list if all treatment slots are occupied by other Title IV-E referrals.

Admission, Treatment and Discharge Process

The Youth SUD Provider:

- Conducts the assessment of the youth to determine treatment service appropriateness.
- Admits the youth for services and completes the CalOMS/LACPRS admission screen.
- Ensures that all releases of information are in place to allow effective communication on treatment progress to Probation Officers directly involved with the youth's case.

- Provides appropriate treatment in accordance with the youth's level of need and as outlined in the Treatment Plan.
- Engages the family/caregivers in services as clinically appropriate, including parent education and family sessions.
- Completes a brief progress summary to the Probation Officer within five (5) business days of the close of each month.
- Discharges the youth from services and completes the CalOMS/LACPRS discharge screen.

Tracking and Data Processes

- Each youth referred to this project must meet the criteria for treatment services, be entered into the CalOMS/LACPRS system, and identified as a "Title IV-E" referral.
- Each participating SUD provider will submit a monthly report to SAPC by the fifth of the following month. The report should indicate the referral date, placement status, admission date, service dates, and discharge status/date for each referred youth regardless of whether direct services were provided or not.
- The PAUR will provide SAPC with a list of the past month's referrals by the 10th of the following month, to verify the number of referrals sent to each participating SUD provider.
- SAPC will inform PAUR by the fifteenth of the following month, about which SUD providers are below their static capacity for this project and discuss ways to increase participation.
- SAPC will provide PAUR with a report by the fifteenth of the following month, on acceptance, rejection, and/or termination on all referred cases.

Staffing and Fingerprint Clearance

- At least one staff person must be assigned to provide direct services to this population.
- This assigned person must receive fingerprint clearance directly through the Probation Department.
- This person could be the same individual fingerprinted for the JJCPA program if the staff-to-patient ratio of 1:15 is not exceeded.
- The Youth SUD provider must inform SAPC immediately of any changes to the duties or employment status of the individuals assigned to this project.

Juvenile Delinquency Drug Court

The Juvenile Delinquency Drug Court (JDDC) program involves the collaborative efforts of the Drug Court Judge, District Attorney, Public Defender, DPO, Court Officer, and the Youth SUD treatment provider on developing and implementing a comprehensive program for diverting nonviolent minors from further involvement in the criminal justice system and SUD behavior.

Target Population

This program is for youth charged by the Juvenile Drug Court for nonviolent, SUD-related offenses.

Program Eligibility

To qualify for this program, a youth must be *both* eligible and suitable for treatment and meet medical necessity.

Eligibility requirements include:

- Ages 14 – 17
- Moderate to heavy substance abuse
- Able to attend court hearings and treatment

Youth eligible for the program will subsequently be assessed to determine suitability for SUD treatment.

Consideration Phase

- To be formally accepted to this program, youth must plead to all open, non-drug related counts. The Prosecutor may dismiss some counts.
- Before the youth is accepted into the program, the DPO completes all court reports including pre-plea, progress, and violation.
- Prior to final admission to this program, youth are in a “consideration” phase during which they attend meetings and participates in counseling and treatment.
- The “consideration phase” is approximately 60 days.
- After youth is accepted into the program, the Drug Court DPO completes the court report if there are any new arrests or violations that may result in termination from the program.
- Youth’s file is immediately transferred back to DPO of Record once the Drug Court DPO completes the supplement or pre-plea report even if disposition is pending.

Program Structure

- Rules:
 1. Youth and family must attend all ordered treatment sessions.
 2. Youth must maintain regular school attendance and/or possess a job.
 3. Youth must not engage in inappropriate or violent behavior toward any program participants or staff.
 4. Youth must not dress in gang attire, shave their head, or obtain new gang tattoos.
 5. Youth must follow all treatment rules, which includes drug testing.
- The Court applies incentives and sanctions to motivate the youth to comply with the program rules.
- Completion of the program is expected within twelve (12) to 18 months depending on medical necessity for treatment and on fulfilling other court requirements. .



SECTION 3.

CLINICAL PROCESS STANDARDS

Quality Improvement & Utilization Management Program

The broad objective of the Quality Improvement (QI) and Utilization Management (UM) Programs is for patients receiving SUD services to receive effective and coordinated care that is the right service, provided at the right time, in the right setting, and for the right duration.

Key goals of the QI and UM Programs include:

- Supporting providers to help patients achieve recovery, stability, and functional improvement.
- Ensuring timely access to high quality, evidence-based, medically necessary SUD services in the most appropriate setting.
- Ensuring effective and efficient utilization of SUD services and resources.
- Facilitating and coordinating care between physical health, mental health, and SUD services.
- Ensuring the provision of services that are age-specific and developmentally, culturally, and linguistically appropriate.
- Involving patient support systems (e.g., family members, significant others), when clinically appropriate.
- Assessing, monitoring, and analyzing clinical performance and utilization, as well as outcome measures, to identify and promote opportunities to work with providers to improve service delivery, patient outcomes, and overall organizational and provider performance.

The QI program is closely interwoven with the UM program to ensure that functions, data, information, decisions, policies, and procedures of one program are aligned and coordinated with the other to assure comprehensive oversight and quality control within the specialty SUD system.

SAPC Committee Structure

A committee structure within SAPC provides a framework for organizational quality improvement and oversight responsibilities. As such, the majority of committees are internal and attended by SAPC branch representatives and relevant parties. However, there are two committees that include external stakeholders, such as providers, consumers, and families, among others. See **Table 14** for additional details.

Table 14. Committee Structure Summary

Committee	Function	SAPC Lead	Minimum Meeting Frequency
Quality Improvement & Risk Management*	Identify opportunities to improve quality of services, compliance and risk management, review documents (records, complaints/grievances, appeals), ensure collaboration and information exchange, and support provider-level quality improvement.	CSA	Every other month
Utilization Management	Evaluate use of medical necessity, provision of services, review initial / ongoing DMC eligibility, identify and monitor over/under utilization of services and risk patterns.	CSA	Quarterly
Finance	Evaluate fiscal priorities and sustainability to ensure alignment with short- and long-term organizational and system priorities.	Finance	Quarterly
Business Technology	Oversee and manage IT-related strategies, projects, and processes to ensure alignment with SAPC mission and objectives.	Information Systems	Quarterly
Capacity and Training	Identify capacity and training needs of SAPC staff and providers, ensure continued professional development and collaboration with other committees.	SND/SPND	Quarterly
Community Liaison (Adult, Youth, and Consumer/Family Member)**	Promote stakeholder collaboration regarding SAPC programming and processes, including the QI and UM process and SUD performance measures. Report stakeholder feedback, knowledge, and suggestions to departmental and organizational leadership.	Systems of Care	Variable
Cultural Competence and Humility**	Evaluate cultural competency and identify opportunities to improve cultural competence of services provided to patients and their families; and promote cultural awareness and sensitivity.	SND/SPND	Quarterly

* Quality Improvement & Risk Management Committee serves as lead committee

** The Community Liaison Committee and Committee on Cultural Competence and Humility will include external stakeholders such as providers, consumers, and families, among others

CSA – Clinical Services and Analytics

SPNDSPNDSPND – Strategic and Network Development

SAPC – Substance Abuse Prevention and Control

Quality Improvement Components

Quality improvement activities help to ensure accessible, quality-focused, evidence-based, effective, and appropriate SUD treatment services. The purpose of the QI program is to assess performance against best practice guidelines to ensure that SUD services follow generally accepted standards of clinical practice in terms of medical necessity, clinical practice, and level of care guidelines, and to continuously improve SUD service delivery. As such, the QI program aligns with SAPC's organizational mission and goals and strives to support the provider network in the provision of quality care and maintain programmatic, clinical, and fiscal integrity to adapt to a changing health care landscape.

Additional elements of the QI program include conducting performance improvement projects, submitting performance measurement data to the State, having mechanisms to detect under- and over-utilization of services, assessing the quality and appropriateness of care provided to patients with special health care needs, implementing a grievance and appeals process, and establishing guidelines for confidentiality and risk management, including ensuring service/billing integrity. The QI program outlines a minimum standard and should not be construed as encompassing the totality of comprehensive SUD care provision.

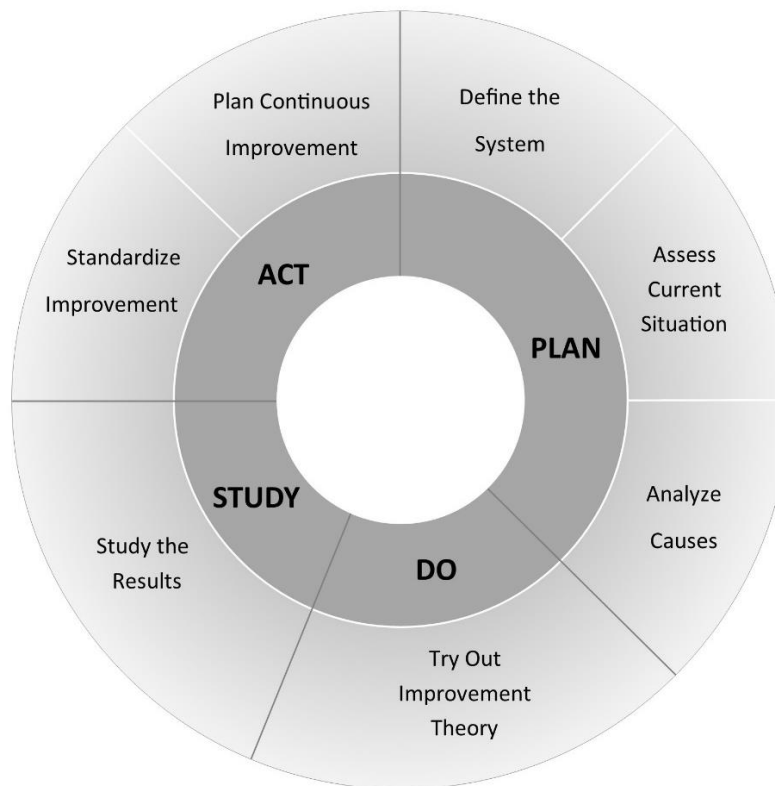
The QI program conducts ongoing Performance Improvement Projects (PIPs) that focus on clinical and nonclinical areas, involving:

- Implementation of system interventions to achieve quality improvement.
- Measurement of performance using objective quality indicators.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

These PIPs are designed to achieve, through ongoing measurements and intervention, significant and sustained improvement in clinical care and nonclinical areas that are expected to have a favorable effect on health outcomes and patient satisfaction.

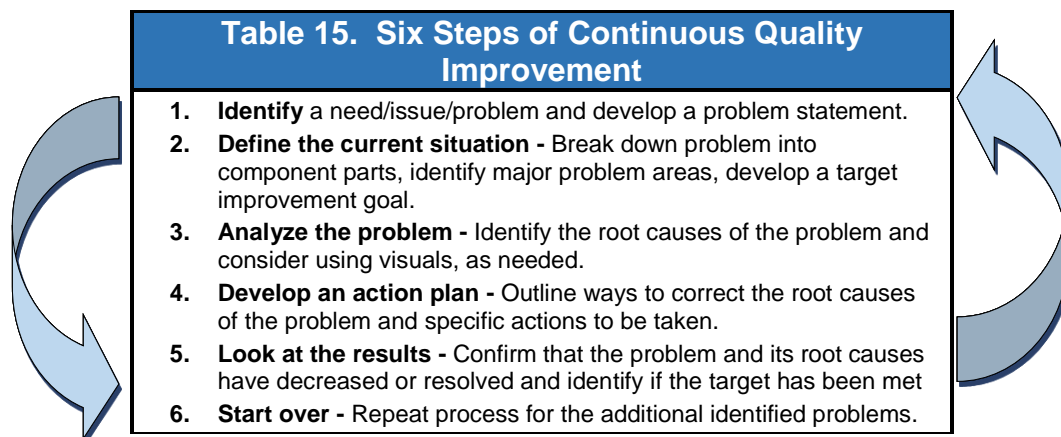
The QI program utilizes the Continuous Quality Improvement Model (CQI) to achieve its objectives. CQI is a respected quality improvement model that has been successfully employed in physical and behavioral health settings alike (see **Figure 4**).

Figure 4. Continuous Quality Improvement (CQI) Framework



The CQI model is based on concepts of quality improvement and performance measurement and employs a patient-centered philosophy and long-term approach to facilitate system improvement. Additionally, this model identifies common causes for variation within a system and is driven by data, process, and patient feedback. The County will continue to work with providers to monitor performance and outcomes as part of the CQI process. Of note, the CQI model is very similar to other cyclical approaches utilized in Public Health (Planning, Implementation, Evaluation, and Review) and is based off earlier quality improvement models of “Plan-Do-Study-Act” activities.

The six (6) steps of CQI are defined in **Table 15**.



Utilization Management Components

The Utilization Management (UM) program analyzes how the SAPC provider network is delivering services and how it is utilizing resources for eligible patients. The various responsibilities of the UM program include:

- Ensuring adherence to established DMC eligibility verification and medical necessity criteria
- Ensuring that clinical care and ASAM level of care guidelines are followed
- Monitoring both under- and over-utilization of services
- Assessing the quality and appropriateness of care furnished to enrollees with special health care needs
- Conducting clinical case reviews (prospective/concurrent/retrospective) of requests for select services
- Authorization of select services
- Random and retrospective monitoring of a portion of provider caseloads
- Ongoing monitoring and analysis of provider network service utilization trends

In summary, the purpose of the UM program is to achieve the following objectives for patients and providers:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum.

- To assure fair and consistent UM decision-making.
- To focus resources on a timely resolution of identified problems.
- To assist in the promotion and maintenance of optimally achievable quality of care.
- To educate health care professionals on appropriate and cost-effective use of health care resources.

SAPC follows federal and state decision and notification timeframes for all UM determinations. SAPC will make every effort to complete UM determinations expeditiously in order to facilitate timely treatment for the patients served in the specialty SUD system in Los Angeles County, and to assure compliance with all requirements.

Eligibility Verification

Initial DMC eligibility verification should occur at the point of first contact between a patient and the specialty SUD system and include considerations outlined in **Table 3**. Medical necessity determinations will occur at the provider site. The initial DMC eligibility verification may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a LPHA (see *Workforce* section) and must be established regardless of the patient's insurance and funding status.

Specialty SUD benefits are available to all patients who meet the requirements of the DMC eligibility verification and medical necessity criteria listed above. Legal status (e.g., parole, probation) is not a barrier to access substance use services, provided that the prospective patient meets the specified DMC eligibility verification and medical necessity requirement. All patients eligible for specialty SUD services (e.g. My Health LA, or participant in qualified county funded programs/projects) will have access to the same benefit package as DMC beneficiaries and will be required to follow the same eligibility and medical necessity verification processes.

Re-verification period for DMC eligibility

- Non-OTP settings: At least every six (6) months
- OTP settings: At least every twelve (12) months

During the re-verification process for DMC eligibility, the LPHA at the provider agency will be required to justify ongoing eligibility for services by verifying DMC eligibility, submitting applicable request forms (e.g., Financial Eligibility Form; Discharge Transfer Form, etc.), and submitting clinical documentation including current Treatment Plan, full ASAM Continuum or SAPC Youth ASAM assessment, progress notes, pertinent miscellaneous notes, and laboratory test results (if available).

All documentation must be submitted at least 21 calendar days in advance of the end date of current DMC eligibility verification in order to prevent the disruption of reimbursable services. The provider agency will be notified of the DMC eligibility re-verification decision within the timeframe listed in **Table 16**.

After the initial DMC eligibility verification and medical necessity determination, UM staff will perform a patient case review in situations that require authorization or pre-authorization to verify that these criteria have been met prior to payment for services. For other cases that do not require authorization or pre-authorization, a random retrospective review of a portion of all

provider caseloads will also ensure fidelity to verification of DMC eligibility and medical necessity criteria.

UM staff have the authority to approve services and reimbursement. If the decision is outside the scope of the UM staff member's authority, the case will be referred to UM management and/or the Medical Director or qualified designee for a determination.

Information for case reviews is obtained from a variety of sources. Although each case is unique, these sources of information may include, but are not limited to, information from the patient or responsible family member, patient record, substance use providers, physical/mental health providers, etc. UM staff will use this information, along with clinical judgment, departmental policies and procedures, needs of the patient, recommendations from providers, and characteristics of the system of care, to render a decision about the provision of SUD services, as needed.

If UM staff determines that DMC eligibility verification and medical necessity criteria have been met, and the proposed or provided services are deemed clinically appropriate, services and reimbursement will be authorized and the applying treatment provider will be notified in accordance with the notification timeframes listed in **Table 16**. Reimbursements for services will be retroactive to the date of the referral submission, pending case review and approval.

If UM staff render a denial determination for DMC eligibility and medical necessity, the case is reviewed by supervisory staff within the UM program. If the decision is consistent with the original denial, the applying treatment provider will be notified of the denial decision within the timeframes listed in **Table 16**.

Adverse DMC eligibility and medical necessity determinations result in denial of reimbursement for services rendered. Denial notifications contain information including, but not limited to:

- Reason(s) including specific plan provisions, clinical judgment used.
- Any additional information needed to improve or complete the claim.
- Descriptions of the appeal process.

Patients, or providers acting on behalf of the patient, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of DMC eligibility, coverage of services, or denial of payment for services (see *Complaints/Grievances and Appeals* section).

Table 16. Utilization Management Notification Timeframes

Review Type	Email/Verbal Decision Notification after Receipt of Completed Request	Written Decision Notification
INITIAL AUTHORIZATIONS and VERIFICATIONS		
Initial Pre-authorization: Residential Services (ASAM 3.1, 3.3, 3.5) (for both adults and youth)	Within 24 hours of receipt of request	Approvals: Within five (5) business days of receipt of request. Other Decisions: See timeframes outlined in the

Review Type	Email/Verbal Decision Notification after Receipt of Completed Request	Written Decision Notification
		<i>Complaint, Grievance, and Appeal Notification Timeframes</i> section below.
Verification of Medical Necessity **Must submit Eligibility Requests within seven (7) calendar days of first service/first intake appointment for adults (ages 18+) or within 14 calendar days of first service/first intake appointment for youth (ages 12-17)	Within five (5) business days of receipt of request	Within seven (7) calendar days of receipt of request
Initial Authorization for: <ul style="list-style-type: none"> Recovery Bridge Housing (<i>only for adults and young adults</i>) Medication for Addiction Treatment for Youth age 17 and under **Must submit authorization requests for these services within seven (7) calendar days (ages 18+) or 14 calendar days (ages 12-17) after patient's admission to the treatment program.	Within five (5) business days	Within seven (7) calendar days of receipt of authorization request
Initial Authorization for: <ul style="list-style-type: none"> Withdrawal Management Services for Youth age 17 and under **Must submit authorization requests for these services within 14 calendar days after patient's admission to the treatment program	Within three (3) business days	Within five (5) business days of receipt of authorization request
RE-AUTHORIZATIONS		
Reauthorization of: <ul style="list-style-type: none"> Residential Services (ASAM 3.1, 3.3, 3.5) *Perinatal patients receiving residential services at PPW sites are authorized for an initial 90 days; and may be reauthorized for another 90 days and every 30 days thereafter, up to 60 days postpartum, based on medical necessity. Recovery Bridge Housing (RBH) *Young adult and adult patients may be authorized and reimbursed for 90 days of RBH and reauthorized for an additional 90 days of RBH if needed, for a potential maximum stay of 180 days per calendar year, based on medical necessity. **Must submit residential and RBH re-authorization request at least seven (7) calendar days in advance of end date of current authorization	Within five (5) business days	Within seven (7) calendar days of receipt of re-authorization request

Review Type	Email/Verbal Decision Notification after Receipt of Completed Request	Written Decision Notification
Re-Authorization for: <ul style="list-style-type: none"> Medications for Addiction Treatment for Youth under age 18 <p>*Must submit reauthorizations at least 14 calendar days in advance of end date of current authorization or verification</p> <p>**There is no reauthorization necessary for withdrawal management services.</p>	<p>Within 14 calendar days of receipt of re-authorization for non-residential services and/or verification of ongoing medical necessity</p>	<p>Within 21 calendar days of receipt of re-authorization request for non-residential services and/or verification of ongoing medical necessity</p>
Verification of Ongoing Medical Necessity <p>*Must submit ongoing verification requests at least 21 calendar days in advance of end date of current authorization or verification</p>	<p>Within 14 calendar days of receipt of re-authorization for non-residential services and/or re-verification for DMC eligibility request</p>	<p>Approvals: Within 21 calendar days of receipt of re-authorization request for non-residential services and/or DMC eligibility verification.</p> <p>Other Decisions: See timeframes outlined in the <i>Complaint, Grievance, and Appeal Notification Timeframes</i> section below.</p>
EXPEDITED AUTHORIZATIONS OR VERIFICATIONS		
<p>If provider indicates or the UM team determines that following the standard authorization timeframe could seriously jeopardize the patient's life, health, or functional status, an expedited authorization process will occur.</p>	<p>As expeditiously as the patient's health condition requires and no later than three (3) business days</p>	<p>N/A</p>

Note:

- These timeframes are only applicable after sufficient information is obtained by UM staff to make a determination. In other words, the clock for these timeframes will not start until UM staff receive sufficient information to make an authorization or verification decision.
- These timeframes may be extended by up to an additional 14 calendar days if:
 - The patient or the provider, requests extension.
 - SAPC justifies (to the State agency upon request) a need for additional information and how the extension is in the patient's interest.
- Providers must submit requests for preauthorized residential services, and intensive inpatient treatment services prior to initiation of services, unless providers elect to provide the service prior to receiving pre-authorization and accept financial loss if the pre-authorization is ultimately denied.
- Any request for Authorization may be denied due to untimely submission (e.g., not submitted in accordance with the timeframes specified above).
- If a patient enters treatment for a preauthorized or authorized service but leaves Against Medical Advice (AMA) before the Financial Eligibility Form is approved, the provider will still need SAPC preauthorization/authorization in order to receive compensation for services provided during the days in which the patient was in treatment.

UM staff will review clinical cases from special SUD treatment providers, including adults, young adults, and youth. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the SUD service continuum. In some instances, these reviews are related to reimbursement of services and in others, the reviews are important and necessary to ensure the quality and appropriateness of services provided. Specialty SUD treatment providers are required to cooperate with all case reviews conducted by the UM program. These reviews are independent from, but complementary with, SAPC contract monitoring activities.

Multidisciplinary UM staff will possess appropriate clinical expertise to evaluate the case and will conduct thorough case analyses, assess for appropriate care that is consistent with generally accepted standards of clinical practice, and determine appropriate utilization of services and resources to ensure that patient needs are met. UM staff will conduct additional research, discuss the case with the requesting provider when appropriate, and consult the ASAM Criteria and/or other appropriate resources.

Information for case reviews is obtained from a variety of sources. Although each case is unique, these sources of information may include, but are not limited to, information from the patient or responsible family member, patient record, substance use providers, physical/mental health providers, etc. UM staff will use this information, along with clinical judgment, departmental policies and procedures, needs of the patient, recommendations from providers, and characteristics of the local delivery system, to render a decision about the provision of SUD services.

Provider caseloads for adults, young adults, and youth at each ASAM level of care will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and pre-authorization (see below). These case reviews are independent from SAPC contract monitoring activities, and the quantity of these reviews will occur at County discretion. UM staff may also conduct focused, retrospective chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted on site and without prior notice to the provider. As needed, UM and Contracts staff will confer on cases to determine the most appropriate responding SAPC entity. These cases will then be addressed, as appropriate.

Utilization Management Case Review Considerations

- **Patient/family/guardian identified goals and preferences.**
- **Care/service is necessary and clinically appropriate in terms of level of care, intervention, frequency, timing, and duration, and considered effective to promote recovery.**
- **Care/service is consistent with generally accepted standards of clinical practice based on:**
 - **Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by independent clinical experts at the time the services are provided.**
 - **Recommendations of a physician specialty society.**
 - **Up-to-date diagnostic criteria from the most current DSM and ASAM criteria.**
 - **Case discussions with treating providers, when appropriate.**
 - **Any other relevant factors.**
- **Case management to ensure that care/service is coordinated both across the continuum of SUD care and across relevant physical and mental health systems, as clinically indicated.**
- **Regular patient assessments ensure that care/service is provided in the least restrictive, most cost-effective environment that is consistent with clinical standards of care.**
- **Care/service is not provided solely for the convenience of the provider, recipient, recipient's family, or custodian (e.g., placing patients in a residential level of care primarily for housing purposes).**
- **Care/service is not experimental, investigational, and/or unproven.**
- **Care/service is deemed necessary and furnished by or under the supervision of an appropriate and authorized licensed practitioner, and in accordance with all applicable rules, regulations, and other applicable federal, state, and local directives.**

The following methods of review are utilized by UM staff:

- **Prospective Review** - A prospective review occurs prior to the delivery of the services and applies to an initial request or for services that require authorization. The prospective review is performed by UM staff, who apply pre-established medical

necessity/appropriateness criteria and render a decision on approval or denial of authorization and/or reimbursement.

- Prospective reviews allow for the opportunity to assure the efficient and appropriate provision of care and utilization of resources, and to continually assess and improve access and quality of care.
- Example of prospective review:
 - Pre-authorization of residential services.
- **Concurrent Review** - A concurrent review examines ongoing care to evaluate medical necessity, and the quality and appropriateness of care. This review is conducted by UM staff, in accordance with pre-established criteria, as previously mentioned.
 - The main objectives of the concurrent review process are to ensure that care is appropriate and in accordance with generally accepted standards of practice, to continually monitor patient progress, and to anticipate treatment needs and transitions that promote recovery.
 - Examples of concurrent review:
 - Authorization of MAT and withdrawal management for patients under age 18
 - Authorization of Recovery Bridge Housing
 - Reauthorization of ongoing MAT for patients under age 18.
 - Reauthorization of ongoing residential services.
- **Retrospective Review** - Retrospective reviews examine various aspects of previously provided services. These reviews yield information about the quality of verification of DMC eligibility and service authorization decisions, and other aspects associated with the services provided to patients. This information is used to evaluate the quality and appropriateness of the services the provider is contracted to deliver. Open and closed cases may be identified for retrospective review through numerous mechanisms.
 - Retrospective reviews allow for the opportunity to identify under- and over-utilization of services, to identify utilization patterns and trends, to continually evaluate the consistency of the UM review and decision-making process, and to continually identify areas of improvement.
 - Example of retrospective review:
 - Random, focused chart review of services that have already been rendered to ensure fidelity to verification of DMC eligibility and medical necessity criteria, as well as quality of care.

The UM program utilizes a variety of methods of review when performing case reviews to monitor care quality and appropriateness, and to inform decisions regarding verification of DMC eligibility, coverage of services, and authorizing reimbursements. Given the complications that can result from the denial of retrospective reviews after the provision of services by providers, whenever possible, prospective and concurrent reviews are preferable to retrospective reviews. The timely submission of Sage authorization requests by providers is helpful in minimizing the potential complications and financial impact of retrospective review denials and is therefore beneficial to the submitting provider.

Summary of Pre-authorized and Authorized Services

- **Services that require pre-authorization**
 - **Residential Treatment (3.1, 3.3, 3.5; excluding residential withdrawal management)**
- **Services that require authorization**
 - **Withdrawal Management for Youth under age 18 (all levels)**
 - **Medications for Addiction Treatment for youth (under age 18)**
 - **Recovery Bridge Housing**

Transitions in Care

When a patient is stepping up or down in level of care, the following documentation is required:

- A Financial Eligibility Form and accompanying clinical documentation, as listed on the Checklist of Required Documentation for Utilization Management Document available on the SAPC website, are required when:
 - A patient is entering the specialty SUD system for the first time, no matter level of care.
 - Stepping down from a residential level of care (ASAM 3.1, 3.3, 3.5) into non-residential levels of care (ASAM 1.0, 2.1, 1-WM, 3.2-WM, OTP) when the individual has already been in the SAPC's SUD system.
- A Financial Eligibility Form, full new ASAM Continuum or SAPC Youth ASAM assessment, and Discharge/Transfer Form are required for patients who are already in the specialty SUD system and transitioning between levels of care when:
 - Seeking placement in a residential level of care (ASAM 3.1, 3.3, 3.5) from any non-residential level of care (ASAM 1.0, 2.1, 1-WM, 3.2-WM, OTP, RSS)
 - Stepping up from a lower level of residential care (e.g. 3.1) to a higher level of residential care (e.g. 3.5)
 - Youth transitioning up or down into any withdrawal management level of care or receiving MAT/OTP services.
- See the [ASAM Assessment Requirements](#) document on the SAPC website for information on when ASAM assessments are required during transitions in levels of care.

Providers must establish that a patient meets medical necessity for the level of care the patient is receiving every six (6) months in non-OTP settings and every 12 months in OTP settings to verify eligibility for specialty SUD services. Required documentation for reverification of medical necessity may be found in the Checklist of Required Documentation for Utilization Management document on the SAPC webpage. For more information about when a new ASAM is required, refer to the ASAM Assessment Requirements for Level of Care Transitions on the SAPC website.

Pre-authorized Services

Services requiring pre-authorization are services for which the treating provider must request approval before initiating treatment. In these instances, UM staff will perform prospective reviews of care that has yet to be provided and concurrent reviews of extensions of previous authorizations, as needed. The only pre-authorized services within the specialty SUD system in Los Angeles County are residential and intensive inpatient treatment.

SUD treatment providers must notify UM staff of the recommended services electronically via Sage in order to begin the pre-authorization review process. Notifications from providers must, at a minimum, include a completed Sage authorization request and initial intake documentation, including assessment information. Providers must submit pre-authorization requests for residential services prior to initiation of services unless providers elect to provide the service prior to receiving pre-authorization and accept financial loss if the pre-authorization is ultimately denied. Requests for continuation of services that require pre-authorization must be submitted at least seven (7) calendar days in advance of the end date of current authorization. Required documentation includes, at a minimum, a completed Sage authorization request, current Treatment Plan, assessment information, progress notes, pertinent miscellaneous notes, and laboratory test results (if available).

UM staff will perform clinical reviews of the case being referred for pre-authorization, based on the case review considerations listed above. Approval for initial Sage pre-authorization requests is based on medical necessity and ASAM level of care guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment.

If a decision determination cannot be made due to insufficient documentation, UM staff will return the Sage authorization request and notify the provider that additional information is needed to process the request.

Table 17. Residential Pre-authorization and Reauthorization Service Limits

Age Group	Initial Residential Pre-authorizations	Residential Reauthorizations	Drug Medi-Cal Service Limits
Youth ages 12 – 17	Initial pre-authorization of 30 calendar days	Reauthorizations required every 30 calendar days, based on medical necessity	N/A
Young Adults ages 18 – 20	Initial pre-authorization of 60 calendar days		
Adults ages 21+			Maximum DMC reimbursable residential length of stay is 90 calendar days, with one 30 calendar day extension in a one-year period, for a total of two (2) residential admissions per year, unless medically necessary. If medically necessary, SAPC will reimburse for more than two (2) residential admissions for adults ages 21 and over using other, non-DMC funds.

Age Group	Initial Residential Pre-authorizations	Residential Reauthorizations	Drug Medi-Cal Service Limits
Perinatal Adults			Maximum DMC reimbursable residential length of stay is up to 60 calendar days after the postpartum period, based on medical necessity for perinatal patients receiving services at PPW sites.
Criminal Justice Involved Adults			Maximum DMC reimbursable residential length of stay is 90 calendar days, with one 30 calendar day extension in a one-year period, based on medical necessity. Extensions may be granted based on the ability to fund additional lengths of residential stay with non-DMC funding

Residential Treatment

Residential services require pre-authorization before services will be reimbursed. This pre-authorization is required for ALL patients needing residential treatment, with the following considerations:

- SUD treatment providers must submit a pre-authorization request to the Utilization Management (UM) Program, which will conduct a prospective review, and then approve or deny the request within 24 hours of receiving the completed request.
 - However, authorizations can only be reviewed when all required elements are received.
- UM requests for missing or incomplete information will result in resetting of time for authorization review and may result in denial due to insufficient information if these requested materials are not provided in a timely manner.
- If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving residential pre-authorization, with the understanding that pre-authorization denials will result in financial loss, whereas pre-authorization approvals will be retroactively reimbursed to the date of admission. For example, a residential treatment provider may choose to accept the financial risk of admitting residential cases during the weekend, with the understanding that the SAPC UM Program will render an authorization decision on the first business day and within 24 hours of receiving the completed request.
- Requests for continuation of residential services must be submitted at least seven (7) calendar days in advance of the end date of current authorization.
- Residential pre-authorizations pertain to the provision of all residential services, including youth, adults, perinatal patients, and criminal justice involved patients, but excluding residential withdrawal management, which are non-authorized services.
- Residential pre-authorizations are required when initiating residential care, transitioning from a lower to a higher level of residential care (e.g. ASAM LOC 3.1 to 3.5), or transitioning from non-residential to residential levels of care.
- Residential lengths of stay (see **Table 17** for additional details)
 - Youth (as defined by EPSDT)

- In general, youth patients typically require shorter lengths of residential stay than adult patients and should be stabilized and then moved down to a less intensive level of care. However, care should be individualized to the needs of the patient. While youth typically require shorter lengths of stay in residential settings than adults, it is also true that they require more external assistance and support and at times more intensive treatment and/or higher levels of care. Higher intensity of service and longer duration of services are not necessarily correlated.
- **Youth under age 18**
 - Initial residential pre-authorizations for youth will authorize no more than 30 calendar days at the outset of residential services.
 - For youth under age 18, residential reauthorizations beyond the initial 30 calendar day authorization will occur every 30 calendar days until the patient turns age 18, with extensions granted based on medical necessity. Upon turning age 18, residential authorization processes for young adults ages 18 – 20 will apply (see above). Once patients turn age 21, residential authorization processes for adults ages 21 and over will apply (see above).
- **Young Adults ages 18 – 20**
 - Initial residential pre-authorizations for young adults ages 18 – 20 will authorize no more than 60 calendar days at the outset of residential services. In other words, residential services for young adults age 18 to 20 require reauthorization after 60 calendar days to assess for appropriate level of care utilization, if determined to require longer lengths of residential care.
 - For young adults ages 18 to 20, residential reauthorizations beyond the initial 60 calendar day residential authorization will occur every 30 calendar days, with extensions granted based on medical necessity until the patient turns age 21. Upon turning age 21, residential authorization processes for adults age 21 and over will apply (see above).
- **Adults age 21+**
 - Initial residential pre-authorizations for adults ages 21 and over will authorize no more than 60 calendar days at the outset of residential services, with the exception of patients who are enrolled in the START program who may be eligible for an initial pre-authorization of 90 days (See Criminal Justice-Involved Patients section below). In other words, residential services for all adult populations ages 21 and over require reauthorization after 60 calendar days to assess for appropriate level of care utilization if adult patients are determined to require longer lengths of residential care.
 - For adults ages 21 and over, the length of residential services ranges from one (1) to 90 calendar days with a 90-calendar day maximum, unless medical necessity authorizes a one-time extension of up to 30 calendar days in a one-year period.
 - For adults ages 21 and over, one extension of residential services up to 30 calendar days beyond the maximum length of stay of 90 calendar days may be authorized for one continuous length of stay in a one-year period

- If medically necessary, SAPC will reimburse for more than two (2) residential admissions for adults ages 21 and over using other, non-DMC funds.
- **Criminal Justice Involved Patients**
 - Patients with in-custody status, participating in the Substance Treatment and Reentry Transition – Community (START – Community) program, can serve the final 90 days of their in-custody sentence in a community residential SUD treatment facility while wearing a Global Positioning System (GPS) ankle monitor. START-- Community patients may be authorized for 90 calendar days of residential SUD treatment (ASAM 3.1, 3.3, or 3.5), if providers include documentation from the Los Angeles County Sheriff's Department (LASD) that identifies patient as a START – Community participant.
- **Homeless Patients**
 - In order to meet the “chronically homeless” definition, an individual must be living in a place not meant for human habitation for at least 12 months continuously, or on at least 4 (four) separate occasions in the last three (3) years totaling 12 months of homelessness. If an individual resides in an institutional care facility, such as an SUD residential treatment facility, for more than 90 days, they will no longer meet the designation for chronically homeless even if they were homeless prior to entering the facility. This is important to keep in mind when applying for residential treatment re-authorizations and identifying available and appropriate housing placements during discharge planning as certain permanent supportive housing resources require the chronically homeless status.
- **Required documentation for initial pre-authorizations for residential services for all populations must, at a minimum, include:**
 - Completed Financial Eligibility Form for residential Sage pre-authorization requests, including justification for residential treatment services
 - Note: If an individual's Medi-Cal application is pending upon admission, the payer in this situation would not be Drug Medi-Cal (DMC) but another funding source based on the individual's eligibility for other programs (e.g., AB 109, Federal Block Grant). To receive payment, providers must complete the ASAM Continuum assessment to establish medical necessity and the minimum CalOMS/LACPRS data set. Additionally, information on other eligible programs (e.g., AB 109, CalWORKs, General Relief) must be completed in CalOMS/LACPRS for payment to be appropriately applied.
 - Full ASAM Continuum or SAPC Youth ASAM assessment information with LPHA signature
- At least one Clinical Service (e.g., individual session, group session) is required each day, including Saturdays and Sundays, in order to claim the residential day rate.
- The minimum and maximum number of hours per week do not change for weeks that include a Federal, State or local holiday. However, the County will consider this during administrative reviews and during monitoring visits. In general, this would not be an audit exception, provided the week prior and the week after the holiday meets minimum and maximum standards.
- For groups to count as a Clinical Service, the session must be conducted for 60 to 90 minutes with a group size limit of 2-12. If these criteria are not met, then the day rate cannot be claimed. Room and board can be claimed when the residential day rate requirements are not met.

- Residential patients must receive regular assessments of their progress within their initial 60 and 30 calendar day residential authorizations for adult and youth populations, respectively.
- **Required documentation for Sage re-authorization requests for residential services for all populations must, at a minimum, include:**
 - Completed Sage reauthorization request
 - Current Treatment Plan updated within the last 30 days and signed by LPHA, counselor and patient.
- Given the fluid nature of clinical progression, the expectation will be that clinical progress notes / miscellaneous notes document progress on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower level of care as soon as clinically indicated. Required Treatment Plan updates every 30 calendar days in the residential setting will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate. Please see *Documentation* section for additional details on Treatment Plan requirements.
- If upon clinical review, either during a focused or random retrospective review, a residential treatment case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for residential services and require transition to an appropriate lower level of care. In these instances, reimbursement for residential services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied.
- SUD treatment providers will be responsible for ensuring successful care coordination during all level of care transitions.
- Providers will be required to notify UM staff of residential discharges and to submit a completed discharge form within 24 hours.

Authorized Services

Authorized services are services that require approval from SAPC, but do not require authorization prior to the provision of services. In these instances, UM staff will perform concurrent reviews of care and extensions of previous authorizations, when pertinent.

The provider will be required to notify UM staff of the recommended services within seven (7) calendar days in order to begin the authorization review process. Any request for authorization may be denied due to untimely submission (e.g., if not submitted in accordance with the timeframes specified above).

Notifications from providers must, at a minimum, include a completed authorization request and initial intake documentation, including assessment information. Required documentation for requests for continuation of authorized services must, at a minimum, include a completed authorization request, current Treatment Plan, assessment information, progress notes, pertinent miscellaneous notes, and laboratory test results (if available).

UM staff will perform clinical reviews of the case being referred for authorization, based on the case review considerations listed above. Approval for initial Sage authorization requests is

based on medical necessity and ASAM level of care guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment. For services that require authorization, notifications will occur within the review timeframes specified in **Table 16**.

Medications for Addiction Treatment for Youth

Authorization for MAT is only required for youth under age 18, with the following considerations:

- Individuals under the age of 18 who initiate medications for addiction treatment (MAT) require authorization.
- **Required documentation for initial authorizations for MAT for youth must, at a minimum, include:**
 - Completed Sage authorization request, including justification for the prescribed medication (e.g., name, dosage, route, frequency, duration, and rationale)
 - Full SAPC Youth ASAM assessment information with LPHA signature
 - Written parental consent for treatment with MAT
 - Laboratory results (if applicable)
- Re-authorization for MAT for youth is required every 30 calendar days, until age 18, if the clinical determination is that patients under age 18 require ongoing MAT.
- **Required documentation for re-authorization requests for MAT for youth must, at a minimum, include:**
 - Completed Sage reauthorization request
 - Current Treatment Plan updated within the last 30 days and signed by LPHA, counselor and patient.
- Requests for continuation of MAT for individuals under age 18 must be submitted at least seven (7) calendar days in advance of the end date of current authorization.

Withdrawal Management for Youth

For young adults (ages 18 – 21) and adults (age 21+), withdrawal management (WM) does NOT require pre-authorization or authorization in any setting. For youth (under age 18), WM is not an ASAM level of care and is therefore not included in the specialty SUD youth benefit package. However, WM may be approved for youth on a case-by-case basis via an authorization process if determined to be medically necessary and may be integrated with services in other settings.

Withdrawal Management for **youth under age 18 requires authorization**, with the following considerations:

- SUD treatment providers must submit a Sage authorization request for youth WM to the UM Program, which will conduct a concurrent review, and then approve or deny the request within three (3) business days of receiving the request.
- SUD treatment providers may admit youth prior to receiving WM authorization, with the understanding that authorization denials will result in financial loss, whereas authorization approvals will be retroactively reimbursed to the date of admission.
- **Authorization for youth WM is required in all WM levels of care for youth, including ambulatory (outpatient), residential, and inpatient.**

- Withdrawal management for youth in residential settings is considered a separate ASAM level of care than youth residential services. As such, only authorization for the youth residential WM services is required and an additional residential authorization is unnecessary unless patients are transitioned to residential services following their episode of WM services.
- Youth WM is authorized for the full duration of the episode of WM service. As a result, reauthorizations and requests for continuation of youth WM services are not applicable.
- The typical duration of WM services ranges from several days to approximately two (2) weeks. Youth WM in ASAM 3.7-WM and 4-WM setting is restricted to a maximum of 14 calendar days, with extensions available according to medical necessity. There is no predetermined length of stay restrictions for youth WM in other settings. Episodes of WM for youth will be monitored.
- Youth receiving WM services must be observed and monitored regularly to assess their progress. The expectation is that youth receiving WM services will be transitioned to a lower level of care as soon as clinically indicated.
- If during a focused or random retrospective review, a youth WM case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to deny ongoing reimbursement for youth WM services, and require transition to an appropriate lower level of care. In these instances, reimbursement for youth WM services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied.
- Treatment for SUDs should occur along a continuum of care and WM is a critical point within the ASAM continuum of care. However, in and of itself, WM does not constitute adequate treatment for addiction. As such, patients who receive WM should be connected with ongoing treatment services for their addiction. Youth WM providers will be responsible for ensuring successful care coordination during all level of care transitions.
- Providers will be required to notify UM staff of youth WM discharges and to submit a completed discharge plan within three (3) business days of ending the service.
- When WM for youth involves medications for addiction treatment (MAT), MAT for youth under age 18 requires authorization (see above).

Recovery Bridge Housing

- If RBH is determined to be appropriate, RBH providers must submit a Sage authorization request and supporting documentation to Sage in order to receive reimbursement for RBH from SAPC
- Staff from the UM Program will review the Sage authorization request form and supporting documentation and render a decision on authorization of the RBH reimbursement. Referring treatment providers must document the need for RBH in the patient's Treatment Plan.
- If patients are self-referring for RBH, staff at the OP/IOP/OTP/OP-WM agency will contact staff at the UM Program who will assess the appropriateness of placement in the RBH setting and render a decision regarding authorization.
- Young adult and adult patients may be authorized and reimbursed for 90 days, and reauthorized for an additional 90 days if needed, for a potential maximum stay of 180 days for patients who meet medical necessity for concurrent OP/IOP/OTP/OP-WM treatment and the eligibility criteria specified in the RBH section of this manual. The 180

days are not required to be continuous and may be used throughout a 12-month period starting from the date of initial RBH admission.

Perinatal patients are authorized for an initial 90 days; and may be reauthorized for another 90 days and every 30 days thereafter, up to 60 days postpartum, based on medical necessity. if the patient is receiving services at a PPW site.

A summary of services that require pre-authorization and authorization is included in **Table 18**.

Table 18. Pre-authorized and Authorized Service Request Timeframes

Service Type	Initial Service Request Timeframe	Ongoing Service Request Timeframe	Notification Timeframe	Reauthorization Timeframe
PREAUTHORIZED SERVICES				
Residential Services; for adults, young adults, and youth	Pre-authorization must be submitted prior to service delivery, unless providers elect to provide the service prior to receiving pre-authorization and accept potential financial loss if the pre-authorization is ultimately denied	Sage re-authorization request must be submitted at least seven (7) calendar days in advance of end date of current authorization	See Table 16	Youth under age 18 Re-authorization required after 30 calendar days, with re-authorizations every 30 calendar days based on medical necessity
				Young Adults ages 18 to 20 Re-authorization required after 60 calendar days for initial residential authorization, with re-authorizations every 30 calendar days based on medical necessity
				Adults ages 21 and over Re-authorization required after 60 calendar days of initial residential authorization, with re-authorizations every 30 calendar days based on medical necessity. An exception exists for specific adult populations, as clinically indicated (see above for details on residential lengths for stay for perinatal and criminal justice populations)
AUTHORIZED SERVICES				
Recovery Bridge Housing (RBH); for adults and young adults only	Sage authorization request must be submitted within seven (7) calendar days of first service/first intake appointment for young adults	Sage re-authorization request must be submitted at least seven (7) calendar days in advance of end date of current authorization.	See Table 16	Perinatal Patients: One), one 90-day Sage reauthorization is allowable, followed by reauthorization requests every 30 calendar days until 60 days after the end of the pregnancy for patients receiving services at PPW sites, based on medical necessity.

Service Type	Initial Service Request Timeframe	Ongoing Service Request Timeframe	Notification Timeframe	Reauthorization Timeframe
	and adults (ages 18+)			Non-Perinatal Patients: Sage reauthorization request is required after the initial 90-day stay, for an extension of another 90 days. One 90-day Sage reauthorization is allowable for a potential maximum RBH stay of 180 days per calendar year for patients who meet medical necessity and the eligibility criteria specified in the RBH section of this manual.
Withdrawal Management for youth under age 18	Authorization must be submitted within 14 calendar days of initiation of service	No reauthorization required Note: Youth withdrawal management services are authorized for the entire episode of service and do <u>not</u> require reauthorization.	See Table 16	No reauthorization required Note: Withdrawal management services are authorized for the entire episode of service and do <u>not</u> require reauthorization.
Medication-Assisted Treatment for youth under age 18	Authorization must be submitted within 14 calendar days of initiation of service	Sage re-authorization request for youth MAT must be submitted at least seven (7) calendar days in advance of end date of current authorization	See Table 16	Re-authorization for youth MAT required every 30 calendar days until age 18, or as clinically indicated

If after careful consideration of all case information UM staff determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the QI and UM programs, services and reimbursement will be authorized and the applying provider will be notified in accordance with the notification timeframes listed in **Table 16**. Reimbursements for services will be retroactive to the date of the referral submission, pending case review and approval.

Denials of authorization will result in denial of reimbursement for services rendered and will be reviewed by supervisorial staff within the UM Program and if the decision is consistent with the original denial, the applying treatment provider will be notified of the denial decision within the timeframes listed in **Table 16**. Denials of authorization will result in denial of reimbursement for services rendered. Denial notifications will include information including, but not limited to:

- The action SAPC has taken or intends to take.

- The reasons for the action.
- The patient's or the provider's right to file an appeal.
- The patient's right of a State fair hearing.
- The procedures for exercising the patient's rights.
- The circumstances under which expedited resolution is available and how to request it.
- The patient's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the patient may be required to pay the costs of the services.

Patients, or providers acting on behalf of the patient, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of service, coverage of services, or denial of payment for services (see Complaints/Grievances and Appeals Process).

Providers – Quality Improvement Expectations

Treatment providers within the specialty SUD system must establish a culture and infrastructure to support continuous quality improvement in order to best serve its vulnerable patient population. This focus on quality necessitates internal processes that support assessment, evaluation, identification of opportunities for improvement, and follow up or action. The following is a description of required quality improvement processes that will facilitate this desired quality-focused culture and infrastructure at the provider agency level.

Peer Reviews

Provider agencies within the specialty SUD system must incorporate peer reviews into their continuous quality improvement activities and establish a formal process for regularly identifying processes or variations in care/services that may lead to undesirable or unanticipated events affecting patients or clinical care. The goal of the peer review process is to establish an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services.

As a component of the peer review process, SUD counselors/clinicians of various disciplines review their colleagues' patient charts and provide feedback on the care that is recommended and provided, in a professional and non-adversarial manner. Reviews should be performed by practitioners within their appropriate scope of practice, and when possible, supervisors should review and follow up with counselors/clinicians in order to provide feedback based on the peer review process. Analyses of clinical decisions and practices should be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards, and national standards.

The focus of these reviews may vary depending on needs determined by the provider agency and may highlight an individual event or aggregate data and information on clinical practices. However, at a minimum, peer reviews must include:

- Review of diagnosis/diagnoses and assessment(s).

- Review of documentation clarity and organization.
- Ensure Treatment Plans are documented and updated accordingly.
- Ensure documentation is signed by appropriate individuals.

The quantity and frequency of reviews may also vary depending on needs determined by the provider agency for each site, but no less than three (3) patient charts for each counselor/clinician must be reviewed twice annually.

All records and information obtained during peer review functions should remain confidential and be used only for the purpose of reviewing the quality and appropriateness of care for improved practices.

Quality Improvement Projects

A quality improvement project (QIP) is a concentrated effort on an identified problem in one area of a provider agency. It involves gathering information systematically to identify and clarify issues or problems and intervening for improvements. The purpose of a QIP is to examine and improve care or services in high-priority areas that the agency identifies as needing attention, which will vary depending on variables including, but not limited to, the population served, workforce, and unique scope and capabilities of services provided. The QIP is not meant to replace other quality improvement projects that organizations may already be using, which may be used or adapted to qualify as their QIP. Each provider is expected to be involved in a minimum of one (1) QIP at all times. SAPC staff will review treatment agency QIPs on an annual basis.

All QIPs should follow the Continuous Quality Improvement model and target improvement in relevant areas of clinical care, either directly or indirectly. Areas of focus may include improving access to and availability of services, improving continuity and coordination of care, improving the quality of specific interventions, enhancing service provider effectiveness, etc. Generally, a clinical issue selected for study should impact a significant portion of the patient population served and have a potentially significant impact on health, functional status or satisfaction. Over time, areas selected for improvement focus should address a broad spectrum of care and services.

Each provider agency must be involved in at least one Quality Improvement Project (QIP) at all times.

These QIPs will be reviewed on an annual basis by SAPC staff.

Performance and Outcome Measures

Healthcare providers, including SUD providers, share the common goal of providing high quality care. Measuring performance and outcomes help organizations and providers understand how well they are accomplishing this goal and allows for an analysis of where and what changes need to be made in the process of striving for continual improvement.

Metrics allow providers to understand what is working well so that others can learn from their success, and also what is not working well so the necessary steps can be taken to seek improvement. The Performance Management System outlined in **Figure 5** provides a framework for how data from performance and outcome measures can be used for process improvement.

Performance and outcome measurement differ as follows:

- **Outcome measures** are used at the patient level to examine changes in substance use behaviors and psychosocial functioning. They are used to understand the effectiveness of treatment services in improving substance use and related functioning of *individuals* who have received treatment.
- **Performance measures** are used at the program level to evaluate how well a program is doing in achieving standards of quality. Performance measures can help identify where service problems exist, which programs are meeting or exceeding expectations of treatment quality, and what, if any, changes should be made to improve service delivery. They inform quality improvement strategies aimed at changing *clinical practices* and *organizational cost management*.

Figure 5. Performance Management System



Source: Public Health Foundation
http://www.phf.org/focusareas/performancemanagement/toolkit/Pages/PM_Toolkit_About_the_Performance_Management_Framework.aspx

Although performance and outcome measurement in the field of addiction are challenging due to the nuances of care that are not always easy to capture in metrics, performance and outcome metrics play a crucial role in moving the field ahead.

As a result, treatment providers operating within the specialty SUD system in Los Angeles County are required to input data into CalOMS/LACPRS, the electronic data collection system that resides within the Sage. **SUD providers are also required to have ongoing**

mechanisms for quality assessment and performance improvement. These metrics help to ensure that Los Angeles County has an evaluation system for its specialty SUD system that allows for continuous improvement and high quality clinical care at the system, provider, and patient level. As such ensuring data integrity is of the utmost importance and to the benefit of providers and patients, and providers are required to develop internal processes to support data integrity efforts.

SAPC recognizes the importance of sharing performance and outcome data with its provider network and encourages providers to leverage available data analytic tools within Sage and their Electronic Health Records (EHRs) to allow for the detailed analysis of their provider- and patient-level data. SAPC will also make every effort to provide metrics to assist providers in their CQI efforts.

Workforce

Increasingly, systems are moving toward a chronic disease and public health model of SUD care that requires a diverse, skilled, and highly trained workforce.

Recommended Responsibilities of Medical Directors and Physicians

- **Provide Medications for Addiction Treatment**
- **Provide withdrawal management**
- **Provide clinical supervision for staff**
- **Refer/treat co-occurring physical and mental health conditions**
- **Assist other professional staff with challenging cases**
- **Lead Quality Improvement functions/projects**
- **Conduct clinical trainings on issues relevant to professional staff**
- **Provide physical exams, when necessary**

SAPC recognizes and values the contributions of contract providers of all sizes and capacities, and also realizes that the composition of a successful SUD system of care must reflect the diversity of needs of the population it serves. While the specialty SUD system has traditionally been staffed primarily by SUD counselors, there is a recognized need to diversify the workforce to include various disciplines and more LPHA staff, including social workers, psychologists, nurses, and physicians. This is particularly important given the requirement for LPHAs to verify medical necessity and eligibility for DMC services and to sign Treatment Plans.

In addition to ensuring the appropriate types and certifications of providers, a robust workforce must

also have sufficient training to ensure that staff have the skillset necessary to meet the needs of its diverse population. As such, trainings and continuing education must be an integral component of professional development, which should include the ASAM criteria and required evidence-based practices (see *Evidence-Based Practices* for more information) for clinical staff.

In summary, it is critical that SUD treatment providers establish a business plan with a hiring and training strategy to ensure that they have the workforce with the background and training necessary to provide high quality SUD services for their patient population.

Medical Director

Each SUD treatment site must have a DMC Medical Director that has been approved by the California Department of Health Care Services (DHCS) by submitting Form 6010.

The Medical Director, or their physician designee, must be on site for **at least two (2) hours per month**. If a physician is unable to meet this requirement for any reason, the agency would need to develop a plan and/or identify an on-call physician to meet this contractual requirement. It is up to each agency to determine what approach best meets this requirement while also meeting their agency needs (for example, agencies could enter into agreements with other SUD providers to fill gaps when they occur).

It is advantageous to utilize staff at the highest level of their license and capability as a result of their education and training. Whenever possible, Medical Directors at SUD provider agencies should perform functions that others (e.g., other types of LPHAs) within the agency are unable to optimally perform.

Minimum expectations of Medical Directors of treatment sites within the specialty SUD system:

- Comply with clinical standards of best practice, licensing, accreditation standards and other local, state, and federal regulatory and reporting requirements. Interpret and support standards and requirements to others.
- Research and maintain knowledge of evidenced-based practices, as well as updates regarding treatment of substance use disorders and recovery-based services.
- Participate in SAPC-related meetings (e.g., Medical Director meetings, Provider meetings)

Recommended Responsibilities of Medical Directors

The following are some recommended responsibilities of Medical Directors and physicians to maximize their benefit and role within the START-ODS system of care. This is not an exhaustive list but is meant to provide guidance on ways Medical Directors and physicians can be fully utilized.

- Provide Medications for Addiction Treatment, when clinically necessary
- Provide withdrawal management, when clinically necessary
- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other professional staff with challenging cases (e.g., refractory SUD, co-occurring conditions, certain special populations)
- Lead Quality Improvement functions/projects (e.g., Quality Improvement Projects, leading clinical team meetings, etc.)
- Conduct clinical trainings on issues relevant to professional staff (e.g., documentation, ASAM Criteria, DSM-5, MAT, co-occurring mental health conditions)
- Provide physical exams, when necessary and appropriate at their facility.

Licensed Practitioners of the Healing Arts

A Licensed Practitioner of the Healing Arts (LPHA) is defined as one of the following professional categories:

- Physician* (MD or DO)

- Nurse Practitioner* (NP)
- Physician Assistant* (PA)
- Registered Nurse (RN)
- Registered Pharmacist (RP)
- Licensed Clinical Psychologist (LCP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed-Eligible LPHA working under the supervision of licensed clinicians

Licensed-eligible LPHAs are persons who have already earned their advanced degree (e.g. MS, MA, MSW, PhD, PsyD, etc.), who are properly registered with their respective state board (e.g. CA Board of Behavioral Sciences [BBS], CA Board of Psychology, etc.) and are authorized to practice under the license of a fully-licensed practitioner with proper supervision as required by the state board with which they are registered. Providers will need to be able to demonstrate compliance with this required supervision and oversight. Within the specialty SUD system, Licensed-Eligible LPHAs can fulfill the functions of independently licensed LPHAs (e.g. Finalize ASAM assessments, make DSM-5 Diagnoses, sign Treatment Plans).

Students, interns or trainees are students who are enrolled in a graduate education program who are working at SUD provider agencies to accrue clinical experience for graduation. They have not yet received their advanced degree in their respective field, do not have registration with the appropriate state board, and are not considered LPHAs. For this reason, (1) these individuals cannot perform the duties of an LPHA (e.g., sign-off on a Treatment Plan or ASAM assessment), and (2) network providers cannot submit claims for treatment services delivered by these individuals.

However, students, interns, or trainees can provide billable services under START-ODS if they register with a State-recognized SUD counselor certifying agency, which includes CCAPP (California Consortium of Addiction Programs and Professionals) and CADTP (California Association of DUI Treatment Programs). Even though registered counselors are able to provide many services without an LPHA's co-signature, because student/interns/trainees are working to earn graduate credit, these providers are required to have co-signatures on all of their clinical documentation and receive weekly supervision. At a minimum, this supervision requirement consists of one (1) hour of individual supervision or two (2) hours of group supervision for every ten (10) hours of direct clinical service provided by the student, intern or trainee.

All potential licensed prescribers* (MDs, DOs, NPs, PAs) in DPH-SAPC's network of care are urged to practice at the top of their licensed capability and to receive sufficient training with MAT to be able to prescribe these medications for addiction on either a routine or case-by-case basis in order to increase patient access to this core component of SUD treatment. Of note, only MDs and DOs with required training and specific DEA X-waivers are permitted to prescribe buprenorphine for addiction.

Minimum Staffing Requirements

Professional staff must be licensed, registered, certified, or recognized under California State

scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their respective scope of practice laws.

Registered and Certified SUD counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8 and must be registered with or certified by one of the National Commission for Certifying Agencies (NCCA) accredited organizations recognized by DHCS: Addiction Counselor Certification Board of California (affiliated with California Association of DUI Treatment Programs (CADTP); and California Consortium of Addiction Programs and Professionals (CCAPP).

To be able to conduct services under START-ODS, registered SUD counselors must have completed the State required ASAM A and ASAM B trainings by the Change Companies. In addition, effective July 1, 2018, Registered SUD counselors must fulfill the following requirements:

1. Complete one (1) classroom course equaling a minimum of 45 hours of formal instruction in an CCAPP or CADTP approved SUD education program by December 31, 2018 that covers one (1) or more of the following topics: SUD counseling, assessment, treatment planning, or case management.
2. Complete an additional 45 hours of training by June 30, 2019 in one (1) additional classroom course (from an CCAPP or CADTP approved SUD education program, **OR** CEU approved continuing education training topics in CBT, MI, ASAM, treatment planning, clinical documentation, or other CEU approved trainings on pertinent SUD topics.

The minimum of one (1) course and additional SUD training equal to or exceeding a total of 90 hours of instruction must be completed by 6/30/2019.

Note: Newly hired registered SUD counselors will have the same classroom/training requirements noted above for existing registered SUD counselors, but will be given a 90-day grace period to complete the one (1) classroom course (45 hours of formal instruction) that is required in #1 above. Newly hired registered SUD counselors must also complete the additional 45 hours of training requirement (see #2 above). A total of 90 hours of education/training must be completed within six (6) months (180 days) of employment start date. START-ODS services conducted by newly hired registered SUD counselors are reimbursable during the six (6) month training period, provided that they complete requirement #1 above (one [1] classroom course equaling a minimum of 45 hours of formal instruction) within the 90-day grace-period of their initial employment start date. If required education/trainings are not completed within required timeframes, services delivered by applicable newly hired registered SUD counselors will not be paid by SAPC and will be eligible for recoupment.

Services in the withdrawal management setting may be provided by registered or certified SUD counselors or LPHA's, depending on the nature of the service with respect to their scope of practice.

All counselors and clinicians (including LPHAs and Licensed-eligible LPHAs), whether full-time,

Training Options

To find available SAPC trainings scheduled for START-ODS on ASAM, DSM5, MAT, CBT, MI, etc., visit publichealth.lacounty.gov/sapc. Click on the “UPCOMING PROVIDER TRAININGS, CONFERENCES, AND IMPORTANT EVENTS” link on the left side of the screen.

Additionally, SAPC has negotiated with The Change Companies (www.thechangecompanies.net) to provide group discounts on the web-based ASAM 1 and ASAM 2 trainings when both modules are purchased. ASAM eTrainings cost \$10.00 per course, per user, per year, as long as least ten (10) subscriptions are purchased. Use the 1ETLA and 2ETLA discount codes when ordering Modules 1 and 2 (for 10 or more users). Discount orders may be placed by calling 888-889-8866 and providing the correct code number.

As many of the training sessions SAPC hosts are provided by UCLA-Integrated Substance Abuse Programs (ISAP), provider agencies can also contact UCLA-ISAP (www.uclaisap.org) directly.

part-time, or on-call, have the same training requirements. The training requirements include: (1) all providers must be trained in the ASAM Criteria prior to providing services and (2) staff conducting ASAM assessments must complete the two (2) e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of care.” In addition, LPHAs (including Medical Director) shall receive a minimum of five (5) hours of continuing education related to addiction every two (2) years and registered and certified SUD counselors shall adhere to all requirements in Title 9, Chapter 8.

It is the providing agency's responsibility to ensure their staff are competent, capable, and appropriately credentialed to provide SUD services, including the ASAM Criteria. Similarly, staff who are unfamiliar with Motivational Interviewing (MI) and/or Cognitive Behavioral Therapy (CBT) are unlikely to be able to effectively utilize one of these required evidence-based approaches. As such, it is highly recommended that provider agencies ensure their staff is adequately prepared prior to providing treatment.

Provider agencies can and should provide workforce development training to their specialty SUD workforce within their agency. SAPC does not maintain a list of

authorized trainers. Therefore, in addition to the requirements for initial trainings, provider agencies retain responsibility for all further training and development of their staff.

Provider agencies are also responsible for ensuring that their staff are appropriately trained on Sage. Staff who are not trained on Sage will not be able to access the system. SAPC has worked with Netsmart to make trainings on Sage available to provider agencies for a nominal fee.

Non-professional staff including clerical, billing, and facility management support shall receive appropriate onsite orientation and training prior to performing assigned duties. Non-professional staff must be supervised by professional and/or administrative leadership. Professional and non-professional staff are required to have appropriate experience and necessary training at the time of hiring.

For more information on what duties each staff can perform, see the *Staffing Grid* on the SAPC website.

Quality Assurance – Regulations

In health care, quality assurance refers to activities and programs intended to achieve improvement and maintain quality of care. Oftentimes, these activities involve ensuring compliance with regulations established by governmental and/or administrative entities. In all cases, key components of quality assurance involve:

- Assessing or evaluating quality
- Identifying problems or issues with care delivery and designing quality improvement activities to overcome them
- Follow-up monitoring to make sure activities achieve their intended aims

In addition to the requirements outlined in this manual, all SUD treatment programs must operate in accordance with Federal and state laws and regulations including those identified below, as well as those outlined in the Mental Health and Substance Use Disorder Services (MHSUDS) Information Notices and relevant All Providers Letters.

Confidentiality

Maintaining appropriate confidentiality is of paramount importance. All SAPC contracted providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with Title 42, Chapter 1, Subchapter A, Part 2 of the Code of Federal Regulations, Part 2 (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) standards, and California State law regarding confidentiality for information disclosure of alcohol and drug use, and other medical records.

42 CFR Part 2 – Confidentiality of Alcohol and Drug Patient Records

Covers all records relating to the identity, diagnosis, and/or treatment of any patient in a SUD program that is conducted, regulated, and/or assisted in any way by any federal agency.

- For a summary of 42 CFR Part 2, please see: <https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2>
- Subpart A includes an introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc.).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, and minor patients, etc.).
- Subpart C covers disclosures allowed with the patients' consent (e.g., prohibition on re-disclosure, disclosures permitted with written consent, disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs, etc.).
- Subpart D covers disclosures that do not require patient consent (e.g., medical emergencies, research, evaluation and audit activities).
- And Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc.).

HIPAA – Health Insurance Portability and Accountability Act

- Provides data privacy and security provisions for safeguarding medical information. A summary of the HIPAA privacy rule can be found here:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>. For more general information on HIPAA, please see: <http://www.hhs.gov/ocr/privacy/index.html>. For more specific information concerning covered entities, consumer information and health information technology, please see <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>.

These laws and regulations must not be used as barriers to provide coordinated and integrated care. Provided that the appropriate patient releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of SUD care, and also across systems of care (physical and mental health, etc.).

Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all providers within the specialty SUD system must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

42 CFR Part 438 – Managed Care

As a participant in Los Angeles County's Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, the administrative entity that is SAPC becomes a specialty managed care plan responsible for overseeing the specialty SUD system. As a component of becoming a managed care entity, SAPC and its specialty SUD network must abide by the 42 Code of Federal Regulations (CFR) Part 438 managed care requirements.

In general, one of the primary aims of 42 CFR Part 438 is to achieve delivery system and payment reforms by focusing on the following priorities:

- Network adequacy and access to care standards (e.g., timeliness of services, distance standards)
- Patient/consumer protections
- Quality of care

CCR Title 22 Drug Medi-Cal and the DMC-ODS Special Terms and Conditions

Title 22 specifies a framework for the expectations and requirements of services delivered through the Drug Medi-Cal (DMC) system. With implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, the Special Terms and Conditions (STCs) of the DMC-ODS specify the new requirements and expectations of the DMC system. Where there is conflict between Title 22 and the DMC-ODS STCs, the DMC-ODS STCs override Title 22. However, Title 22 remains as the regulatory requirements in all other areas that are not in conflict with and not addressed by the DMC-ODS STCs.

California Code of Regulations (CCR) Title 9 Counselor Certification

CCR Title 9, section titled Counselor Certification provides minimum requirements on the level of credentials counseling staff secure prior to conducting services. The minimum standards are designed to ensure a baseline quality of treatment services and effectiveness. The County has

built on these requirements and established minimum staffing standards specific to Los Angeles County.

For additional information, please see the *Staffing Grid* in the Network Provider section on the SAPC website.

Evidence-Based Practices

Evidence-based practices (EBPs) are interventions that have been shown to be effective and are supported by evidence. In Los Angeles County, although other psychosocial approaches may be used (e.g., relapse prevention, trauma informed treatment, and psychoeducation), SUD treatment agencies must at a minimum implement Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).

Providers are also expected to support the use of medications for addiction treatments as an evidence-based intervention, when clinically appropriate.

Motivational Interviewing

A patient-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem solving or solution-focused strategies that build on patients' past successes. According to the Motivational Interviewing Network of Trainers, MI "is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

Cognitive Behavioral Therapy

According to the National Institute of Drug Abuse's *Principles of Drug Addiction Treatment: A Research-Based Guide*, "Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it. A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use and developing strategies for coping with cravings and avoiding those high-risk situations." The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.

Other Contractor Selected Practices

Relapse Prevention

According to SAMHSA's *National Registry of Evidence-Based Programs and Practices*, relapse prevention is "a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain

gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide patients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a patient's overall coping capacity."

Trauma-Informed Treatment

According to SAMHSA's concept of a trauma-informed approach, "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in patients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization." Seeking Safety is an example of an evidence-based trauma-informed practice.

Psychoeducation

Psychoeducational interventions educate patients about substance abuse and related behaviors and consequences. The information provided may be broad but are intended to lead to specific objectives. Psychoeducation about substance abuse is designed to have a direct application to patients' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist patients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Documentation

Clinical documentation refers to anything in the patients' health record that describes the care provided to that patient, and its rationale. It is observational and narrative in content and is written by counselors and clinicians to analyze the process and contents of patient encounters.

Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

- 1) Ensure comprehensive and quality care** – The process of writing initial assessments and proper progress notes requires thought and reflection. Preparing proper clinical documentation serves an important role of helping assure quality patient care by giving practitioners an opportunity to think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work, and weigh alternative approaches to the care. Good clinical documentation helps one organize clinical details into a case formulation that can then be used for Treatment Planning and is an essential element of professional practice and of the provision of quality clinical services. It also helps to assure appropriate utilization of team members from multiple disciplines in order to leverage interdisciplinary competencies and maximize the quality of services provided.
- 2) Ensure an efficient way to organize and communicate with other providers** – The documentation of clinical care helps to provide structure and efficiency to clinical communications with other providers who may be involved in the care of shared patients. This assures coordinated rather than fragmented treatment/service delivery.
- 3) Protect against risk and minimize liability** – Accurate and comprehensive clinical documentation is not only important in terms of quality care but is also essential in risk management. Detailing and justifying the thought processes that contributed to the clinical decision-making process helps to support the adequacy of the clinical

assessment, the appropriateness of the treatment/service plan, and demonstrates the application of professional skills and knowledge toward the provision of professional services.

- 4) **Comply with legal, regulatory and institutional requirements** – Good clinical documentation practices help to assure compliance with recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations, and rules. It also helps to ensure that documentation meets the standards set by specific accreditation programs (e.g., CARF, Joint Commission), when applicable, and by health care institutions, facilities and agencies.
- 5) **Facilitate quality improvement and application of utilization management** – Clinical documentation provides an opportunity to explain the process and substance of assessments, treatment and service planning, clinical decision-making, medical necessity, and the effectiveness of treatments and other services provided. As a result, it is essential for the utilization review process because clinical documentation helps to substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or services. From a quality perspective, clinical documentation facilitates supervision, consultation, and staff/professional development, and helps to improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be taken. Appropriate recordkeeping also provides data for use in planning educational and professional development activities, policy development, program planning and research in agency settings.
- 6) **Clinical documentation must be credible and complete and is protected via HIPAA and 42 CFR Part 2.** It encompasses every aspect of clinical care, including initial assessments, progress notes, and relevant encounters that occur outside of established appointments. Documentation of initial assessments follows the same format as the multidimensional ASAM assessment and reflects a comprehensive biopsychosocial approach. Progress notes are written during/after follow-up appointments in order to gauge clinical progress and assess to determine if patient needs have changed and if modifications to the treatment approach/plan are required. The style of documentation is expected to be consistent and standardized throughout the agency/institution (e.g., everyone uses the same progress note format).

In general, clinical documentation includes the following characteristics:

- Notes that are dated, signed, and legible.
- Patient name and identifier are included on each page of the clinical record.
- Patient's race, ethnicity, and primary language spoken.
- Referral information.
- Sources of information are clearly documented.
- Patient strengths and limitations in achieving goals.
- Limited use of abbreviations and, when used, abbreviations are standardized and used in a consistent context.
- All relevant clinical information and reflects a biopsychosocial approach to the assessment process.
- Patient self-report of experiences.

- Reflects changes in patient status including response to and outcome(s) of the intervention(s), progress towards goals and completion of objectives, and transitions in care.
- The counselor's/clinician's professional assessment and continued plan of action.
- Documentation of changes in patient status are documented (e.g., change in level of care provided or discharge status).
- Description of how services provided reduced impairment, restored functioning, and/or prevented significant deterioration as outlined in the Treatment Plan.
- For patients with limited English proficiency, documentation if interpreter services were offered and provided, and an indication of the patient's response.

Treatment Plan

Patient-centered care is critical and requires that patients be provided the opportunity to actively shape their Treatment Plans.

As patients advance through treatment, the corresponding Treatment Plan should be reviewed and updated accordingly based on stability and the likelihood of rapid changes in patient condition. Treatment Plans should be updated more frequently if an individual is unstable or if there is a notable event that requires a change in the Treatment Plan. See **Table 19** for additional detail regarding minimum requirements for Treatment Plan Reviews and Updates. **It is important to note that these are maximum timeframes and the ideal scenario is to complete and sign the Treatment Plan as expeditiously and close to the treatment admission date as possible.**

Table 19. Treatment Plan Minimum Requirements

Treatment Plan Activity	Level of Care	Minimum Requirement
<p><u>Initial Treatment Plan</u></p> <p><i>NOTE: Initial Treatment Plans must be performed on standardized Treatment Plan templates on Sage or approved by SAPC.</i></p>	All Withdrawal Management levels of care	Must be completed upon intake and signed by patient and LPHA within the treatment episode
	Outpatient Intensive Outpatient Residential	<p>Must be completed upon intake within seven (7) calendar days of first service or first intake appointment for adults (18+), including signatures by both patient and LPHA</p> <p>OR</p> <p>Within 14 calendar days of first service or first intake appointment* for youth (ages 12-17) including signatures by both patient and LPHA.</p>
	Opioid Treatment Program	Must be completed upon intake within seven (7) calendar days, and signed by patient and LPHA within 28 calendar days of admission
<p><u>Treatment Plan Review</u></p> <p><i>NOTE: Treatment Plan Reviews involve a review of a Treatment Plan. If the Treatment Plan</i></p>	Outpatient Intensive Outpatient Opioid Treatment Program	Every 30 calendar days, at minimum
	Residential	Every 15 calendar days, at minimum

Review results in a determination that changes to the Treatment Plan are not necessary, a Miscellaneous Note or Progress Note stating that a Treatment Plan Review was completed must be included in the patient's record. If Treatment Plans require modification, a Treatment Plan Update should be performed.		
<p><u>Treatment Plan Update</u></p> <p>NOTE: Treatment Plan Updates involve a review of a Treatment Plan. If the Treatment Plan Review results in a determination that changes to the Treatment Plan are needed, Treatment Plan Updates must be performed on standardized Treatment Plan templates on Sage or approved by SAPC.</p>	Outpatient Intensive Outpatient Opioid Treatment Program	Every 90 calendar days, at minimum
	Residential	Every 30 calendar days, at minimum

If a patient's condition does not show improvement at a given level of care or with a particular intervention, then a review, abbreviated assessment, and Treatment Plan Update should be made in order to improve therapeutic outcomes. Changing the level of care or intervention should be based on a reassessment and modification of the Treatment Plan in order to achieve an improved therapeutic response.

Treatment Plans must meet the requirements specified in the AOD certification standards, Title 22, CCR, Section 51341.1 (h)(2)(A), or for Opioid Treatment Programs, Title 9, CCR, Section 10305, as specified in Title 22, CCR, Section 51341.1(h)(2)(B).

At a minimum, Treatment Plans should include:

- Thorough documentation of case details, including a diagnosis and statement of problems to be addressed.
- Goals that are mutually established between patient and provider for each identified problem.
- Action steps to be taken by the provider and/or patient in order to achieve the identified goals.
- Target dates for the achievement of identified action steps and goals.
- Description of the type(s) and frequency of services to be provided. If the frequency changes, then a Treatment Plan update needs to be completed to prevent disallowances.
- Required documentation, as specified in Titles 9 and 22, including documentation of physical examinations.

- The patient shall review, approve, type or legibly print their name, sign and date the initial Treatment Plan and Treatment Plan Update, indicating whether they participated in preparation of the plan, within 7 (ages 18+) or 14 (ages 12-17) calendar days of the first service or first intake appointment. If the patient refuses to sign the Treatment Plan, the provider shall document the reason for refusal and the provider's strategy to engage the patient to participate in treatment. **See Table 4. SAPC Access and Services Delivery Standards for more information.**
- If the LPHA determines the services in the Treatment Plan Update are medically necessary, the LPHA shall type or legibly print their name and, sign and date the Treatment Plan Update within 15 calendar days of signature by the SUD counselor.
- When medications are included in the Treatment Plan in OTP settings, LPHAs who sign off on Treatment Plans must be licensed prescribers. This is NOT a requirement in non-OTP settings, as prescribers may be in different systems of care or agencies.

Progress Notes

For reassessments and level of care transitions, initial and relevant progress note documentation are based on the ASAM criteria and include the following information:

- Date ASAM placement criteria were used.
- Documentation of the name, location and primary contact at referral site.
- Format of ASAM criteria used (software or paper-based).
- Justification of discrepancy if the level of care suggested by ASAM criteria is not recommended by counselor/clinician.
- Justification of discrepancy if the discussed level of care is not agreeable to patient.
- Justification of discrepancy if the level of care the patient was referred to does not match the level of care suggested by the ASAM criteria.

Progress notes or miscellaneous notes (under document titled "Miscellaneous Note Option") must be documented for all patient encounters and services in all settings. Documentation is necessary for providers to demonstrate that services have been delivered in accordance with respective service hour requirements. Miscellaneous notes offer a free text and less extensive documentation option compared to progress notes.

Standardized documentation by SUD counselors and clinicians assist with increasing treatment consistency and quality of care and reducing reimbursement disallowances. As such, SAPC requires that the multidimensional components of the ASAM criteria be incorporated into initial documentation of the first full assessment, and that progress notes for both individual and group sessions follow one of four formats: SOAP, GIRP, SIRP, or BIRP.

SOAP (Subjective, Objective, Assessment and Plan) is an acronym that describes the structure of a specific style of progress note documentation. The SOAP format is widely used and improves the quality and continuity of patient services by providing a consistent and organized framework of clinical documentation to enhance communication among health care professionals and better recall the details of each patient's case. This format allows providers to identify, prioritize and track patient problems so they can attend to them in a timely and systematic manner. It also provides an ongoing assessment of both the patient's progress and the treatment interventions. While a full review of the SOAP note format is beyond the scope of

this document, **Table 20** outlines a summary of its components and providers should refer to additional resources for more information.

Table 20.

SOAP Progress Note Format	
S	Subjective – Patient statements that capture the theme of the session. Brief statements as quoted by the patient may be used, as well as paraphrased summaries.
O	Objective – Observable data or information supporting the subjective statement. This may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
A	Assessment – The counselor's or clinician's assessment of the situation, the session, and the patient's condition, prognosis, response to intervention, and progress in achieving Treatment Plan goals/objectives. This may also include the diagnosis with a list of symptoms and information around a differential diagnosis.
P	Plan – The treatment plan, based on the assessment and clinical information acquired.

The **GIRP**, **SIRP**, and **BIRP** progress note formats are also used to record similar clinical information in a structured format. The information included in these progresses note formats includes patient goals/situation/behavior, staff interventions used during the session, patient response to the session, and the plan for future sessions or progress made toward the Treatment Plan. Similar to the SOAP note format, GIRP, SIRP, and BIRP notes provide a standardized structure for documentation that better ensures a comprehensive and consistent quality of care. **Table 21, 22, and 23** summarize the key components of GIRP, SIRP, and BIRP progress notes, although a full review of these standardized formats is beyond the scope of this document. Providers should refer to additional resources for more detailed information.

For patients with multiple health problems, the problems can be numerically prioritized according to severity and treatment need in the plan section for the respective progress note format.

Table 21.

GIRP Progress Note Format	
G	Goal – Patient's current focus and/or short-term goal, based on the assessment and Treatment Plan.
I	Intervention – Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	Response – The patient's response to intervention and progress made toward individual plan goals and objectives.
P	Plan – The treatment plan moving forward, based on the clinical information acquired and the assessment.

Table 22.

SIRP Progress Note Format	
S	Situation – Patient's presenting situation at the beginning of intervention. May include counselor/clinician observations, patient's subjective report and the intervention setting.

SIRP Progress Note Format	
I	Intervention – Provider’s methods used to address the patient’s statements, the provider’s observations, and the treatment goals and objectives.
R	Response – The patient’s response to intervention and progress made toward individual plan goals and objectives.
P	Progress – The treatment plan progress made toward treatment goals and objectives, as well as the plan for future interventions as determined by the clinical picture.

Table 23.

BIRP Progress Note Format	
B	Behavior – Patient statements that capture the theme of the session and provider observations of the patient. Brief statements as quoted by the patient may be used, as well as paraphrased summaries that closely adhere to patient statements. Provider observations may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished, etc.), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
I	Intervention – Provider’s methods used to address the patient’s statements, the provider’s observations, and the treatment goals and objectives.
R	Response – The patient’s response to intervention and progress made toward individual plan goals and objectives.
P	Plan – The treatment plan moving forward, based on the clinical information acquired and the assessment.

Residential Progress Notes

Residential progress notes can be completed by encounter on a daily basis or as weekly summaries that describe progress on Treatment Plan goals and provide a record of services provided during the week. If weekly summaries are used, as specified in Title 22, they must include all necessary components of treatment sessions including:

- Description of patient progress towards Treatment Plan goals.
- Record of patient attendance
- Record of SUD counselors/ LPHAs in attendance
- Date of each treatment session
- Start and end time of each treatment service
- Topic of treatment sessions
- Printed or typed & signed name of LPHA or counselor. Counselor and LPHAs signatures should be next to each other when both are required.

SAPC recommends daily notes because it is very challenging to incorporate all required elements of weekly summaries without extensive tracking and documentation of the services provided within a given week. In some cases, writing daily notes may be easier or more efficient than writing weekly notes. However, the minimum requirement is that progress notes be documented on at least a weekly basis in residential settings if it meets the minimal documentation standards above. Importantly, if providers are already writing notes for every service delivered on a daily basis, the weekly summary is NOT necessary.

Miscellaneous Notes

Miscellaneous notes offer a free text and less extensive documentation option compared to progress notes. Documentation of patient encounters and services that do not fit into the progress note format can be documented on the Miscellaneous Note Option. Miscellaneous notes do not replace the need for progress notes or other documentation but should supplement other available documentation formats and be used when using other formats are not appropriate.

Examples of Service Documentation Appropriate for Miscellaneous Notes

- **Case management services**
- **Collateral information gathered from patient family members**
- **Any other pertinent information related to a case that the provider wants to be acknowledged as having been performed, but which does not fit the format of other available documentation options such as progress notes, Treatment Plans, discharge and transfer documents, etc.**

Discharge Summary and Transfer

Treatment providers within the specialty SUD system must submit discharge/transfer summaries to SAPC when their patients discharge or transition care. This information is intended to document a summary of the treatment episode, discharge reason, overall prognosis, follow-up plans, and other pertinent information that is necessary to ensure sufficient care coordination, as well as high quality and effective SUD service delivery.

In Sage, the Discharge/Transfer Form will need to be submitted when (1) a patient is stepping up or stepping down between residential levels of care OR between outpatient levels of care (e.g., ASAM level 2.1 to level 1.0); and (2) a patient is being discharged from any level of care (e.g. they are not stepping up or down to other levels of care). The Sage Recovery Bridge Housing Discharge form is required to be completed on the same day of discharge from their recovery bridge housing stay.

Complaints/Grievances and Appeals Processes

A complaint/grievance and appeals process is available for patients, their authorized representative, or providers acting on behalf of the patient and with the patient's written consent ("involved parties"). A complaint is the same as a grievance.

An "appeal" refers to a request for review of an "action," which may include:

- Denial or limited authorization of a requested service such as the type or level of service.
- Denial, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.

A “grievance” or complaint refers to an expression of dissatisfaction about any matter other than an “action,” as defined above. Possible subjects for complaints/grievances include but are not limited to: the quality of care of services provided; the timeliness of service provision, aspects of the interpersonal relationships such as rudeness of a provider or employee; and failure to respect the patient’s rights.

Involved parties may contact the Contracts Unit in these instances to discuss their concerns. In many cases, a responsible and reasonable resolution can be achieved through an informal and professional discussion. However, additional action in the form of a complaint/grievance or appeal may be required in some instances. Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution. The QI and UM programs, Finance Unit, or the Contract Unit is responsible for processing these complaints/grievances and appeals, depending on the circumstances, nature of the situation, and the responsibilities of the respective unit.

SAPC will provide patients reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

At the level of the SUD treatment agency, providers must have policies and procedures in place for collecting, reviewing, and acting on complaints/grievances/appeals that are filed by their patients. This process should be clear and transparent to all patients and providers and should be integrated into the quality improvement processes of the provider agency.

Similarly, patients, their authorized representative, or providers acting on behalf of the patient and with the patient’s written consent have the opportunity to file a complaint/grievance and/or appeal. Involved parties may review and respond to the evidence and rationale provided by QI and UM staff in instances of denials of authorization and may challenge denials of DMC eligibility verification or service authorizations for levels of care.

Complaint/Grievance Process

Providers may initiate complaints/grievances verbally or in writing **at any time**. Patients can file a complaint with SAPC by phone or in writing via web application or mail by submitting a Patient Complaint Form. If patients do not submit a written Patient Complaint Form, SAPC staff will complete the Patient Complaint Form based on the information provided by the patient. A patient may also authorize, in writing, another person as an (“authorized representative”) to act on the patient’s behalf.

- Upon receipt, complaints/grievances will be logged by SAPC Contracts staff. Clinically-related complaints/grievances will be forwarded to the SAPC QI and UM staff for review.
- The staff making decisions on complaints/grievances will not have been involved in any previous level of review or decision making and are health care professionals with appropriate clinical expertise.
- Patients and/or providers are entitled to a full and fair review conducted by QI and UM staff that possess the appropriate clinical expertise.
- All clinical complaints/grievances will be reviewed by supervisory staff within the QI and UM Programs, who will work with QI and UM staff and the involved party/parties filing the complaint/grievance to research all facts associated with these inquiries and conduct

additional research, such as contacting the treating provider, if necessary. Every attempt will be made to achieve a satisfactory resolution, if applicable.

- A written acknowledgement of receipt and a written decision notification regarding the grievance will be rendered within the timeframes listed in **Table 24**, though many complaints/grievances will be addressed sooner. If the clinical complaint/grievance cannot be resolved within the respective timeframe, an extension of 14 calendar days may be requested by either the beneficiary or the County. Extensions may only be initiated by the county when there are delays due to the need for additional information AND it is in the best interest of the patient.
- Decision notifications will include, but not be limited to:
 - The date and result of the grievance.
 - Reasons and rationale for decision (if decision result in denial).
 - Contact information for the reviewer.
 - Information regarding the state fair hearing process and the patient's right to continue to receive benefits while the State Fair Hearing is pending.
- In instances in which appeals are denied and not wholly resolved in favor of the patient, patients must be notified of:
 - The right to request a State Fair Hearing and how to do so.
 - The right to request to receive benefits while the State Fair Hearing is pending, and how to make the request.
 - The possibility the patient may be held liable for the cost of those benefits if the State Fair Hearing decision upholds the original denial decision.
- Clinical complaints/grievances will be addressed as a component of the quality improvement activities within the QI and UM Programs and depending on the nature of the complaint/grievance, may trigger more targeted follow up at the provider level.
- Concerns that arise during the complaint/grievance process will be discussed with SUD treatment providers and are viewed as a learning opportunity for both QI and UM staff and providers, with the shared goal of improving our system of SUD care.
- Complaints/grievances may be presented to the Quality Improvement & Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.

Appeals Process

Utilization management decision makers are not incentivized or rewarded to issue adverse decisions (e.g. denials). The goal of the UM program is to ensure appropriate utilization of SUD resources and is NOT intended to screen out patients for necessary services or create unnecessary burden for providers, which is contrary to the organizational mission and goals of SAPC.

Appeals offer an opportunity for additional review and reconsideration of adverse decisions in instances in which patients, their authorized representative, or providers may disagree with the decisions rendered by UM staff. In these circumstances, parties may file a formal appeal to challenge denials of DMC benefit verification, level of care decisions, or payment for services.

Patients and/or providers are entitled to a full and fair review. Appeals reviewers will consist of supervisorial and/or higher management staff. The appeals process timeline is outlined in

Table 24. Appeals Process Timeline

Activity	Timeline		Reference/Notes/Questions
What is the timeline for submission of an Appeal?	Within 60 days of Notification of Adverse Decision (date on letter)		Consistent with CMS sample documentation from DHCS
Timeline for notification of receipt of appeal (SAPC Appeal Acknowledgement Letter)	Standard	Five (5) business days	SAPC Appeals Policy
	Expedited	Three (3) business days	SAPC Appeals Policy Reflects change in language from 72 hours to three (3) business days (State standard is three (3) business days)
Timeline for SAPC Rendering Decision on Appeal (Appeal Determination Letter).	Standard	30 days after receipt of appeal (date on appeal form).	**Consistent with CMS sample documentation from DHCS Reflects change in language from 72 hours to three (3) business days (State standard is three (3) business days)
	Expedited	Three (3) Calendar Days	
Timeline for submission of Fair Hearing Appeal to the State	Within 120 days after Denial of Appeal		

Appeals can be submitted in writing by forwarding a completed Appeal request to the QI and UM Program, either electronically or via fax within 60 calendar days from the date of the written decision notification for the Sage authorization request. See below for contact information. Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing by SAPC, unless the patient or the provider requests expedited resolution. Patient or SUD treatment providers may file an appeal either orally or in writing, and unless they request expedited resolution, must follow an oral filing with a written, signed, appeal.

- Upon receipt, appeals will be logged by QI and UM staff and receipt notification will be sent to the requesting party within the timeframes outlined in **Table 25**.
- Staff reviewing the appeal request will research the facts associated with the initial denial and conduct additional research, such as contacting the treating provider, if necessary. Reviewers will also consult the ASAM criteria and/or other appropriate clinical resources.
- The patient is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. SAPC will inform the patient of the limited time available for this in the case of expedited resolution.
- After careful consideration of all case information, a decision will be rendered, and the rationale and outcome will be conveyed to the appealing patient and/or provider, in accordance with the timeframes outlined in **Table 25**. If the appeal cannot be resolved

within the respective timeframe, an extension of 14 calendar days may be granted by a UM supervisor.

- Decision notifications include, but are not limited to:
 - The date and result of the appeal.
 - Reasons and rationale for decision (if decision result in denial).
 - Contact information for the reviewer.
 - Information regarding the state fair hearing process and the patient's right to continue to receive benefits while the fair hearing is pending.
- In instances in which appeals are denied and not wholly resolved in favor of the patient, patients must be notified of:
 - The right to request a State Fair Hearing and how to do so.
 - The right to request to receive benefits while the hearing is pending, and how to make the request.
 - The possibility the patient may be held liable for the cost of those benefits if the State fair hearing decision upholds the original denial decision.
- Appeals for initial residential authorizations, and withdrawal management and MAT for youth will be expedited, according to the timeframes outlined in **Table 25**, whereas residential reauthorizations will follow the standard appeal timeframe.
- The expedited resolution of appeals begins when SAPC determines (in response to a request from the patient or patient representative) or the provider indicates (in making the request on the patient's behalf) that taking the time for a standard resolution could seriously jeopardize the patient's life, health, or functional status. The SUD treatment provider will be notified within the timeframe listed in **Table 25**.
- The patient and their representative should have an opportunity, before and during the appeals process, to examine the patient's case file, including medical records, and any other documents and records considered during the appeals process.
- Concerns that arise during the appeals process will be discussed with SUD treatment providers, may result in corrective actions, and are viewed as a learning opportunity for both QI and UM staff and providers, with the shared goal of improving our system of SUD care.
- Appeals will be presented to the Quality Improvement & Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.
- During the appeal process, the patient continues to receive their benefits if all of the following are met:
 - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
 - The services were ordered by an authorized provider.
 - The patient or the patient's representative requests extension of benefits.
- If, at the patient's or patient's representative's request, SAPC continues or reinstates the patient's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
 - The patient withdraws the appeal.
 - A State fair hearing office issues an unfavorable hearing decision to the patient (e.g., denial).

- The time period or service limits of a previously authorized service has been met.
- Patient responsibility for services furnished while the appeal is pending.
 - If the final resolution of the appeal is unfavorable to the patient (e.g., denial) and upholds SAPC's action, SAPC may recover the cost of the services furnished to the patient while the appeal is pending, to the extent they were furnished solely because of the appeal.
 - If SAPC or the State fair hearing office reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, SAPC must authorize and provide the disputed services promptly.
 - If SAPC or the State fair hearing office reverses a decision to deny authorization of services, and the patient received the disputed services while the appeal was pending, SAPC must pay for those services.

Contact Information:

County of Los Angeles, Department of Public Health
 Substance Abuse Prevention and Control
 Office of the Medical Director and Science Officer
 1000 South Fremont Avenue; Building A-9 East, 3rd Floor
 Alhambra, California 91803
 (626) 299-4193

In all cases, patients who have exhausted the Complaint/Grievance and/or Appeals process may request a State Fair Hearing process with the California Department of Health Care Services.

Table 25. Complaint, Grievance, and Appeal Notification Timeframes

Description	Receipt of Notification	Written Decision Notification
<p>Complaint/Grievance A process of expressing dissatisfaction with elements of care including, but not limited to, quality of care, services, and/or treatment.</p>	Within five (5) calendar days of receipt of complaint/grievance	Within 90 calendar days of receipt of complaint/grievance
<p>Standard Appeal for Residential Reauthorizations, Grievance Decisions, etc.</p> <p>Appeals are a formal process of challenging adverse decisions involving, but not limited to, DMC eligibility, services, or level of care decisions.</p> <p>*Must be filed within 60 calendar days from the date on the written decision notification/Notice of Adverse Benefits Determination.</p>	Within five (5) calendar days of appeal	Within 30 calendar days of receipt of appeal
<p>Expedited Appeal for Initial Residential Authorizations, and Withdrawal Management and Medication-Assisted Treatment for Youth under age 18.</p> <p>The expedited resolution of appeals begins when SAPC determines (in response to a request from the patient or patient representative), or the provider indicates (in making the request on the patient's behalf), that taking the time for a standard resolution could seriously jeopardize the patient's life, health, or functional status. Appeals for initial residential authorizations and medication-assisted will be routinely expedited.</p> <p>*If request for expedited resolution of an appeal is denied, it will be transferred to the timeframe for standard resolution. Written notification of this change to a standard appeal process will be provided within 72 hours.</p>	Within 72 hours of receipt of expedited appeal	

Note: These timeframes may be extended by up to an additional 14 calendar days if:

- The patient or the provider, requests extension;

- SAPC justifies (to the State agency upon request) a need for additional information and how the extension is in the patient's interest.
 - SAPC will provide the patient and provider written notice of the reason for the delay and inform the involved parties of the right to file a grievance if they disagree with that decision. SAPC will issue and carry out its determination as expeditiously as the patient's health condition requires and no later than the date the extension expires.

Risk Management and Reportable Incidents

Risk management refers to strategies that minimize the possibility of an adverse outcome or a loss and maximize the realization of opportunities. Good risk management techniques improve the quality of patient care and reduce the probability of an adverse outcome and resulting liability to the health care provider. Standards of care, quality improvement, and the systematic gathering, analysis, and utilization of data are the foundations of risk management.

Risk Management Committee at the Provider Level

There is a growing need and importance of risk management strategies in an evolving health care landscape, including in the specialty SUD system. As a result, each treatment provider agency providing services within the specialty SUD system is responsible for having a Risk Management Committee.

The functions and responsibilities of providers' Risk Management Committees must be systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency.

The goals and activities of the provider Risk Management Committees should include:

- To assure implementation of an agency-wide risk management strategy that includes development of policies and procedures, and subsequent staff trainings, relating to quality improvement, fire safety, disaster preparedness, hazard reporting, etc.
- To assure a review, tracking, and documentation system for all reportable incidents, including follow up and implementation of any corrective action until follow up is no longer indicated.
- To provide thorough investigation on all reportable incidents, which must be reported to SAPC.
- To investigate adverse events, as necessary and appropriate.
- To review safety and incident related data and to identify trends and patterns associated with risks or to identify problem areas.
- To establish processes to maintain service/billing integrity and quality care, including implementation of peer review processes and Quality Improvement Projects.
- To promote quality improvement activity through identifying opportunities towards maximizing safety of physical and therapeutic environment and reducing agency, staff, and patient risks.
- To develop procedures aimed at detecting and preventing fraud, waste and abuse.

Adverse Events

Adverse events are defined as incidents that have a direct or indirect impact on the community, patients, staff, and/or the SUD treatment provider agency as a whole and are required to be

investigated and evaluated at the provider agency level. This information should be used on a routine basis to improve accessibility, health and safety, and address other pertinent risk management issues.

Reportable Incidents

Reportable incidents are patient safety events that result in death, permanent harm, and/or severe temporary harm, and/or intervention required to sustain life.

Contracted providers are required to report provider-preventable conditions in accordance with [MHSUDS 17-046](#) and the [Reporting Form](#).

Reportable incidents must be investigated by the provider's Risk Management Committee and must be reported to the SAPC Quality Improvement & Risk Management Committee immediately. These incidents may result in corrective actions and are viewed as learning opportunities to improve care and risk management processes.

While reportable incidents must be reported to the SAPC Quality Improvement & Risk Management Committee, adverse events and other risk management and quality-related issues may be reported to SAPC at the discretion of the leadership of the SUD treatment provider agency.



SECTION 4.

BUSINESS PROCESS STANDARDS

Contract Management

The Contracts and Compliance Division (CCD) works with all contracted service providers to ensure full and accurate understanding and efficient management of their contract. This includes:

- Updating Provider's Contract
- Ongoing Compliance Monitoring
- DHCS Auditing and Corrective Action Plan Support
- Contractual and Regulatory Technical Assistance

Additionally, CCD is responsible for maintaining an avenue for new and existing SUD providers to join the network or add new services to their contract. To achieve this, CCD develops and maintains a solicitation process that is fair, open and reflective of the County's need while setting a minimum standard of qualifications to ensure the highest level of treatment services for SUD patients.

How to Join SAPC's Provider Network or Add Services

Whether looking to join SAPC's provider network or adding services, the first step requires that treatment providers have all the mandated certification or licenses. Because DMC is the primary funder of the SUD system all treatment levels of care, except for RBH, SAPC requires DMC Certification for all treatment providers. The County established a set of minimum requirements to ensure that the specialty SUD provider network is diverse and qualified. Additional information is available at the following links:

Interested in becoming a SAPC Contracted Provider?

<http://publichealth.lacounty.gov/sapc/interest.htm>

The information available at this link instructs treatment providers how to register as a Vendor with LA County. Not only will this allow treatment providers the opportunity to apply to become a contracted provider, it will also notify treatment providers of any other funding opportunity with the County.

DMC Contract Application

Treatment providers interested in joining the network must successfully complete the DMC Contract application process. This includes meeting all the certifications, licenses, staffing, and financial requirements. The application is found at the above link and provides detail requirement information.

To access, visit: <http://publichealth.lacounty.gov/sapc/funding/DMC/DMCAApplication.htm>

DHCS DMC Certification Application

DMC is the primary funder of all SUD treatment in the network. Any provider seeking to provide SUD treatment services must be DMC certified to provide that level of care. This includes new providers to the network or current providers who wish to provide additional services under their existing contract. The link provides information and DMC certification application. Providers should note the following:

- The State of California's Department of Health Care Services is solely responsible for administering and processing the DMC certification process.
- Certification is site specific. Providers should identify any and all sites where treatment is offered and ensure the DMC certification application reflects this information.
- Accuracy is key. Providers should make every effort to review their application for accuracy and completeness. The DMC certification process can be timely, a provider's careful attention may increase the likelihood of approval.

To access, visit: <http://www.dhcs.ca.gov/provgovpart/Pages/DMC-Forms.aspx>

DHCS ASAM Designation

In addition to the DMC certification, all network treatment providers must have the appropriate ASAM designation on their Alcohol and Other Drug (AOD) license. Much like the DMC Certification application process, this is a State-run process and providers should be mindful to submit accurate and complete information to increase the likelihood their application is approved in a timely manner.

For more information, visit: <http://www.dhcs.ca.gov/provgovpart/Pages/ASAM-Designation.aspx>

Updating Service Provider's Contract

Contracts may be updated to reflect changes at the local, State and Federal levels. Contracts may also be updated at the request of the service providers wishing to update their organization's information or wishing to add or remove services.

SAPC Updates

Contracts may be periodically amended to reflect changes at the local, State and Federal levels that impact the delivery of SUD treatment. These amendments may come in the form of a new contract or via a SAPC Bulletin. Providers will be notified of all pending changes in a timely manner and be mandated to attend trainings or meeting on the new changes.

Service Provider Changes

Service Providers may wish to update, add, or remove services to their contract to reflect changes in the organization. Below is a table to help providers better navigate the contract amendment process.

Table 26. Process for Contract Amendments

Contract Action	When do I do this?	How do I do this?	How long does this take?
Funding Augmentation	Providers should monitor their funding utilization and requests any increases or decreases as needed. Funding augmentations are approved based on utilization,	Submit a letter to SAPC Director and include the requested amount and a clear justification.	3 to 4 months

	performance, and County need.		
Add/Remove Services or locations	Providers may wish to add or remove services based on new certification or as a result of organizational changes.	Providers wishing to add services should submit a request to add services to the SAPC Director and include: <ul style="list-style-type: none"> • Licenses and/or Certifications. • Purchase contract, rental/lease agreements • Zoning or City Permits • Days/Hours of Operation • Contact information including address, phone, fax and email • Any other relevant information 	2 to 3 months
Update Staff Names	As part of the contract, providers are required to notify SAPC of any program leadership changes.	Notify SAPC in writing of the new staff and describe his/her role and title.	1 month
Another Changes	Much of the service provider's information is entered in to a database. Any organizational changes should be reported to SAPC to ensure the most current and accurate information.	Notify SAPC in writing of any organizational changes.	Varies

Ongoing Compliance Monitoring

As the steward of both tax payer funds and SUD treatment in LA County, SAPC is mandated to ensure treatment is delivered in an appropriate and effective way and in accordance with contractual, state and federal requirements. To ensure this, all service providers will undergo various types of monitoring, including:

SAPC Compliance Monitoring

Contracts and Compliance Division conducts ongoing compliance visits with providers to ensure full and appropriate understanding and application of contractual, local, State and Federal requirements. Each organization is assigned a Contract Program Auditor (CPA) which serves as the service provider's main point of contact for most non-clinical issues. The relationship between the service provider and the CPA is one of collaboration and partnership. The CPA conducts compliance checks and works with the service provider to correct any identified non-

compliance issues. The CPA will work with the service provider to develop and implement a Corrective Action Plan that address and resolve all the deficiencies encountered during the monitoring visit.

In accordance with governing regulations around the use of tax-payer funds, some deficiencies may result in a repayment of funds to the County. The CPA can provide guidance to ensure a repayment plan is implemented, if needed.

State Monitoring

In accordance with AOD licensing and DMC Certification standards, the State of California's Department of Health Care Services also conducts audits/reviews of treatment providers. These include Fiscal Reviews and Post Services/Post Payment reviews. Contracts and Compliance Division will work with the treatment provider to resolve any issues identified in the audit by collaborating on the Corrective Action Plan and ensuring its successful implementation. In addition to State audits, providers are also required to submit Single Audit report to the State if they receive \$750,000 in Federal awards per year.

County Fiscal Monitoring

Fiscal monitoring is a review of the service provider's financial records to verify the compliance with the financial aspects of the contract and generally accepted accounting principles. The fiscal monitoring follows the same cycle as contract monitoring. However fiscal monitoring focuses on the following areas:

- Accounting Records: to obtain an overview of the contractor's operations.
- Cash Position: to determine if the contractor is fiscally viable.
- Financial Condition: ensures if contractor maintains positive working capital.
- Billing/Expenses: service units and operating expenses are verified for accuracy.
- Payroll: verify if appropriate staff are hired and payroll taxes are not delinquent.

Contractual and Regulatory Technical Assistance

Understanding all the regulations that govern services is critical to implementing a successful program. Contracts and Compliance Division staff works with providers to ensure understanding and appropriate implementation of all contractual and regulatory requirements. Service providers should contact their Contract Program Auditor with any questions or to request technical assistance.

Regulations to be familiar with:

- Contract/Agreement
- This Provider Manual
- Title 22 & 9
- Perinatal Practice Guidelines
- Certification Standards (DMC and AOD)
- State and County Youth Treatment Guidelines
- HIPAA & Title 42 CFR/CRF
- Title 42 CFR, part 438
- Federal Register
- Special Terms and Conditions (STCs) of the DMC-ODS waiver

SAPC Provider Policy Requirements

In accordance with the County's State contract, providers are mandated to develop and implement policies to ensure adherence to laws and guidelines that regulate substance use disorder treatment. In addition to those mentioned throughout this manual, below is a list of policies that providers are required to have:

- Record Retention: Ensure both clinical, administrative and financial records.
- Program Integrity: Develop a committee comprised of high level staff to implement policies aimed at detecting and preventing fraud, waste and abuse.
- Organizational Changes: Develop a procedure to ensure SAPC of any organizational changes including change in services, locations or high-level staff.
- Training: Ensure that staff are properly training on aspects of the START-ODS including, ASAM.

Finance Management

How Network Providers are reimbursed for services has changed, and will continue to do so, with Los Angeles County participating in the DMC-ODS Waiver and the resulting SUD system transformation. Therefore, key business management practices need to be in place and monitored regularly (e.g., monthly) to ensure that persons served, and units of services claimed align with costs incurred. Any excess funds resulting from rates that exceed actual costs should be reinvested on allowable business and clinical capacity building efforts well in advance of the end of the fiscal year. Long-term viability and sustainability will depend on the agency's ability to grow and retract costs/expenditures-based staff productivity as a result of delivering medically necessary treatment services at the right level of care.

Rates and Standards

The *SUD Rates and Standards Matrix* details allowable Healthcare Common Procedure Coding System (HCPCS) codes and the associated service description, rate, unit of service, and treatment standard for each level of care. The minimum number of hours required does not change for weeks that include a Federal, State, or local holiday.

Outpatient levels of care (ASAM 1.0, 2.1, 1-WM, 1-OTP, RSS) report by HCPCS codes and get reimbursed by HCPCS codes at the associated rate. Residential/Inpatient levels of care (ASAM 3.1, 3.3, 3.5, 3.2-WM, 3.7-WM, 4.0-WM) report by HCPCS codes and get reimbursed by day rate, and room and board rate.

Gathering this information for all levels of care is needed both to:

- Understand the average and per person service mix and service frequency by provider and level of care; and
- Inform the real cost of delivering medically necessary treatment services for use in the rates development process for the next fiscal year.

For this reason, it is critical that network providers report all delivered services even when the service is not currently reimbursable (e.g., alcohol/drug tests, screening) or when there are no minimum number of service hours required per day (e.g., ASAM 3.2-WM, 3.7-WM, 4.0-WM).

For residential services (ASAM 3.1, 3.3, 3.5), however, it will be critical to document the total hours of services delivered each week to demonstrate meeting the per person standard (20, 24, and 22 hours respectively) and substantiate that patients are receiving services at the appropriate level of care.

The Sage System is configured to include the treatment standards outlined in the *SUD Rates and Standards Matrix*, and thus will disallow claims that exceed the standard, and send notifications and/or reduce payment if claims are below the standard. Examples:

- 1) **Intensive Outpatient (ASAM 2.1):** For youth service hours are between six (6) and 19 hours per week and adult service hours are between nine (9) and 19 hours per week (Perinatal service hours are between nine (9) and 30 hours per week). If the minimum hours of service are not met, reimbursement will be reduced to the ASAM 1.0 rate. If minimum service units are not met for four (4) or more weeks, the patient needs to step down to a lower level of care and further reimbursement will be disallowed.
- 2) **High Intensity Residential Non-Population Specific (ASAM 3.5):** For youth and adults service hours are at least 22 hours per week. If less than eleven (11) hours of service are provided per week, for more than two (ages 12-17) or three (ages 18+) weeks, the patient needs to step down to a lower level of care and further reimbursement will be disallowed. When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in the progress notes. Alerts will be sent via Sage if service unit minimums are not met. Claims cannot be submitted to the County if a Sage pre-authorization request has not been submitted and/or approved by the County, or in the event of an unauthorized extension.

The Sage system will also automatically calculate the group counseling and patient education

Example: How to Calculate Group Counseling Sessions

The Department of Health Care Services' (DHCS) group services billing formula has changed and is now based on the duration of the group session and no longer fluctuates based on the number of participants. Additionally, SAPC has updated the Rates and Standards Matrix to allow providers to submit claims for documentation time for group counseling sessions, provided it does not exceed the following standards and represents actual time documenting notes tailored to each participant:

- a. 2-4 participants one 15-minute unit;
- b. 5-8 participants up to two 15-minute units; and
- c. 9-12 participants up to three 15-minute units.

The number of minutes would be added to the total time submitted for the group session, but it must be clear what amount of time relates to the time spent conducting the group versus the time spent documenting individualized group session notes. Note: OTP group rates are billed in 10-minute units.

claims per person based on the established formula and ensure compliance with the group size (2-12 persons regardless of payer) and duration (60-90 minutes) limits. It will also have the capability to determine whether the following requirements are met:

- 1) **Enrollment in Multiple Programs:** An individual cannot be concurrently enrolled in two or more levels of care (except Opioid Treatment Programs and Recovery Bridge Housing) or be enrolled by more than one contractor at a time (except Opioid Treatment Programs and Recovery Bridge Housing).
- 2) **Recovery Bridge Housing Reimbursement with Treatment:** Recovery Bridge Housing participants must be concurrently enrolled in OP (ASAM 1.0), IOP (ASAM 2.1) OTP (ASAM 1-OTP), or ambulatory withdrawal management (ASAM 1-WM) services for providers to receive RBH reimbursement.
- 3) **Lack of Services:** If services are not provided for 30 days an alert will be sent via Sage to notify the contractor to discharge the individual. If after 45 days no services have been provided, an administrative discharge will automatically be completed, and the County monitors will discuss the deficiency at the next site visit.

Review the *SUD Rates and Standards Matrix* included in the Network Provider section on the SAPC website for more information on allowable services and standards by level of care.

Cost Reconciliation Not Cost Reimbursement

SAPC contracts are now reimbursed at the lesser of costs or charges. This means at the end of the fiscal year; final payment will be based on cost reconciliation not cost reimbursement.



Cost Reconciliation:



Settle up to, but not to exceed, the rate for services delivered to patients where allowable costs align with SAPC requirements including business and clinical capacity efforts outlined in the DHCS approved Fiscal and Rates Plan. This means if fee-for-service claims for patients served are below incurred costs, SAPC does not pay the difference (e.g., a loss).



Cost Reimbursement:



Settle up to the substantiated costs of delivering services to patients which may exceed the established rates. This meant if fee-for-service claims for patients served was below incurred costs, SAPC paid the difference. This process ended for all SAPC contract agencies as of June 30, 2017.

To avoid recoupment of previously paid service claims, all submitted costs must be allowable and within any specified amount or range. If the total amount paid by SAPC exceeds reported and substantiated costs, the contractor will be required to repay the County within the specified timeframe and in accordance with the repayment terms.

If approved services were provided that exceeded the contract amount and the opportunity to increase the contract funding allocation has expired due to fiscal year end, SAPC will reimburse for those services at cost reconciliation contingent upon the provider justifying the cost. Currently, this process has been fast tracked to within six (6) months after the submission of the cost report to the State.

Projecting Utilization and Managing Expenditures

It is important to view the agency's budget in terms of how many patients and units of medically necessary services need to be delivered to fund the fixed and variable costs: People = Payment. If it costs \$120,000 to support the costs associated with a particular facility (e.g., staff, supplies, rent, utilities, training), the agency needs to know how many patients need to be served and how staff productivity is assessed on a regular basis to meet targets.

However, the foundation of the new treatment system of care is the delivery of *medically necessary* services. Therefore, this means patients cannot be served at a higher or lower level of care than is clinically appropriate and cannot receive more services than is minimally necessary to achieve positive health and recovery outcomes.

The California Institute for Behavioral Health Solutions (CiBHS) developed a spreadsheet titled *Projecting Service Capacity and Revenue* that enables providers to enter information from each budget line-item and experiment with utilization using either a 15-minute increment (e.g., outpatient) or a day rate (e.g., residential) to determine service targets. Agencies are encouraged to enter claims data from the previous fiscal year and budget line-item amounts for the current fiscal year to determine whether there will likely be overspending (not enough patients to cover costs) or underspending (not enough costs to support payment) if no business changes are made. If overspending occurs, agencies should meet with clinical staff to determine whether outreach needs to occur to bring in new patients and/or if productivity needs to improve to reduce the amount of time dedicated to non-billable activities. If underspending occurs, agencies should assess what business and clinical investments (e.g., computers, technology, training, staff, salaries) should be made to support improved patient care and outcomes. This tool can also be used to determine how many more people need to be served to support new staff positions, new sites, livable wages for staff, and so on. The Network Providers, Capacity Building and Training Resources tab on SAPC's website includes the outpatient and residential version of this tool and a recorded webinar to help agencies get started with this process.

Requests to increase funding allocations are based on performance, utilization, and need. Providers seeking additional funding should send a request to the SAPC Director and Contract Services Division. Requests must include a justification that addresses these three (3) criteria: performance, utilization, and need. Based on this information and funding availability, SAPC may approve, deny, or modify the amount requested. Requests made solely on projected need will not be approved.

Capacity Building to Support a Modern SUD System

When designing the new reimbursement structure under the DMC-ODS Waiver, SAPC included various allowable capacity building costs in the *Finance and Rates Plan* approved by DHCS to enable Network Providers to make clinical and business improvements to better achieve long-term outcomes for patients. Network Providers are expected to evaluate clinical and business practices to determine whether the current efforts align with best practice and support an efficient and effective system of care, and to make investments when gaps or medications are needed. Depending on the organization's cash flow, some agencies may be able to make investments right away whereas others may need to do so later in, but prior to the end of the fiscal year, to allow time to accumulate funds since the rate received may exceed current operating costs. To know when to invest, organizations must understand the budget in relation

to the cost reconciliation reimbursement model as well as projected and actual service utilization (e.g., patients served, units of service).

For the entire SUD system of care to transition to a modern healthcare delivery system, it is necessary for all Network Providers to see the value in making investments that directly or indirectly impact clinical care and the service environment, take steps to determine what is needed, and then enacting change. The following capacity building efforts are strongly encouraged and can be included if the budget provided expenditures do not exceed any limits (and comply with any federal, state or local regulations/requirements (see **Table 26**). Making some of these and other allowable investments will also enable Network Providers to implement and comply with requirements outlined in other sections of this Provider Manual.

Table 27. Allowable Clinical and Business Investments

ALLOWABLE & ENCOURAGED CLINICAL AND BUSINESS INVESTMENTS	
Need	Considerations
Benefits Acquisition: No eligible Medi-Cal or My Health LA individual can be turned away because the application has not been submitted or is in-process, or the renewal is incomplete. Case management needs to be used to help patients acquire benefits while concurrently receiving treatment.	<ul style="list-style-type: none"> • How many billable services are lost when Medi-Cal or My Health LA eligible beneficiaries are turned away for lack of current benefits? • Who is assigned to help patients acquire benefits? • Are there processes in place to track and confirm eligibility monthly? • Is training required? • Is equipment required?
EHR or Sage: Use of an approved electronic health record (EHR) is required. Sage will be available soon and free of charge for agencies who do not wish to purchase their own EHR.	<ul style="list-style-type: none"> • Is it better to use Sage? • Does your computer system meet expectation in SAPC Bulletin #17-02? • Do you have enough computers for counselor and clinical staff?
Facility Environment and Access: Each outpatient site (except OTP) must provide services two evenings (5PM-9PM) per week and 8 hours per weekend. Having a welcoming facility may also contribute to patient satisfaction and retention.	<ul style="list-style-type: none"> • Do you comply with new service day and hour standards? • Would expanding days and hours of operation increase services? • Would minor facility improvements (e.g., paint, furniture) impact patient care?
Field-Based Services: Field-Based Services are allowable at select non-agency operated sites provided the location has been pre-approved by SAPC.	<ul style="list-style-type: none"> • Are there costs associated with any of these sites? • Are there any transportation (e.g. mileage) costs? • Do you have equipment (e.g., computers, cell phones) that can protect patient confidentiality if lost/stolen?

Table 27. Allowable Clinical and Business Investments

ALLOWABLE & ENCOURAGED CLINICAL AND BUSINESS INVESTMENTS	
Need	Considerations
Medications for Addiction Treatment: Clinical and counselor staff need to be able to educate, refer and link all patients with opioid and alcohol use disorders on this available treatment option.	<ul style="list-style-type: none"> • Are staff trained? • Do policies and procedures reflect this requirement? • Are referral mechanisms in place?
Qualified Staff: LPHAs can perform some functions previously performed by the Medical Director. There are also new staffing requirements that begin July 1, 2018.	<ul style="list-style-type: none"> • Will improved salaries or benefits for direct service staff increase retention and reduce turnover? • Would hiring LPHAs in addition to counselors improve patient care? • Are new managers needed to monitor quality assurance and utilization/claims?
Trainings for Clinical and Counselor Staff: <ul style="list-style-type: none"> • ASAM Criterial and Medical Necessity • Cognitive Behavioral Therapy • Motivational Interviewing • Culturally and Linguistically Appropriate Services (CLAS) 	<ul style="list-style-type: none"> • How many staff need training? • How often are trainings? • Who will conduct the trainings? • Will SAPC trainings be enough?
SBAT and SASH: The Substance Abuse Service Helpline (SASH) will schedule appointments in real time whenever possible and the Service and Bed Availability Tool (SBAT) must be updated daily.	<ul style="list-style-type: none"> • Is a receptionist or other staff always available during regular business hours? • What are the potential losses in referrals if nobody is available to receive SASH calls? • How will the SBAT be updated?

Previously, some of these decisions may have been determined by program or clinical administration staff, with or without sufficient funding allocated in the budget. However, with new service standards, patient choice, and the need to meet utilization projections, it is critical for fiscal staff to make sure budgets address service needs. Ultimately, the more skilled the organization is with engaging and retaining patients in medically appropriate services that address individualized needs and preferences, the more likely the organization will be able to make further investments that contribute to business growth. Understanding the relationship between clinical and business operations are critical under this new managed care model, and these clinical and business investments should assist in the transition at the organizational level. Communication with agency staff as well as research and analysis will be key to determining what investments are right for an agency's organization and patients.

Budget Development Process

Now that the County and its Network Providers is operating under a managed care model, it is even more critical that the budget and expenditures clearly align with both the business and clinical needs of the organization. Therefore, when agencies build the annual budget for all

agency-operated locations, it is critical to fully articulate the essential expenditures that will support compliance with federal, state, and local regulations, expectations outlined in this Provider Manual and other contract-related documents, and substantively contribute to positive patient outcomes.

One budget template called the *Budget Summary Template and Budget Narrative* will be used by all Network Providers. Code of Federal Regulations (CFR) Chapter 2 Office of Management and Budget Guidance, part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ([2 CFR part 200](#)) governs reimbursement related to Federal funds. Each Network Provider will submit one budget that complies with 2 CFR part 200 and include detail by agency-operated site address; any costs associated with FBS need to be estimated and detailed under the associated agency-operated site. Costs can either be direct or indirect:

1. **Direct Costs:** Typical direct costs include, but are not limited to, compensation for employees who provide treatment, their related fringe benefits costs, the costs of materials and other items of expense incurred for treatment. These costs can be specifically identified with a particular final cost objective. ([2 CFR, § 200.413](#)).
***Note:** Meal costs are only allowable in residential and inpatient programs (ASAM 3.1, 3.3, 3.5, 3.2-WM, 3.7-WM, 4.0-WM); snack costs are only allowable when provided to minors (ASAM 1.0-AR, 1.0, 2.1). Non-SAPC funds must be used for all other food purchases. Food costs must be reported under the "Food and Snacks" line item under "Services and Supplies" category and be clearly tracked and managed.*
- 2) **Indirect Costs:** Typical indirect costs include, but are not limited to, depreciation, cost of operating and maintaining facilities, general administration and general expenses, such as the salaries and expenses of executive officers, personnel administration, accounting and utilities. These costs are incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. ([2 CFR, § 200.414](#)).

The budget summary template is divided into two parts:

A. Budgeted Direct Costs:

- Salaries, Wages and Employee Benefits
- Facility Rent or Lease
- Equipment and/or Other Asset Leases
- Services and Supplies

B. Budgeted Indirect Costs:

- Salaries, Wages and Employee Benefits
- Facility Rent or Lease
- Equipment and/or Other Asset Leases
- Services and Supplies

While the major budget line-items (a-d) are the same, the included information will either be specifically tied to a service site address (Direct Costs) or will be associated with more than one service site and/or administration site (Indirect Costs).

Claims Submission and Reimbursement Process

Providers will submit claims through the electronic billing system (e.g., Sage) by the 10th of each month. SAPC staff retrieves the Providers' billing invoices by contract number and by reporting period. SAPC staff then verifies the payment amount information calculated by the system that is due for the reporting period. Adjustments for Accounts Receivables are also applied due to Audit findings, Cost Report Settlements, and refunds.

SAPC's reasonable timeline to process payments is 15 calendar days after receipt of an invoice, which is the 25th of each month. The County Auditor Controller's Office issues the checks and mails them to the agencies, unless a direct deposit is on file.

Claims Submission Process: Medi-Cal Eligible or My Health LA Eligible but Not Enrolled

Network Providers will be reimbursed for delivered treatment services for up to 60 days after admission, assessment, and completion of CalOMS/LACPRS for:

- Medi-Cal eligible patients whose complete Medi-Cal application is submitted but not processed by the 60th day or ultimately denied
- My Health LA eligible patients whose completed My Health LA application is submitted but not processed by the 60th day or ultimately denied
- Medi-Cal patients whose benefits need to be re-assigned to Los Angeles County due to a permanent move

If a patient has not been granted Medi-Cal or had benefits transferred to Los Angeles County after 60 days, an agency can continue to provide services, but services are not reimbursed by SAPC

Table. 28 Claims Submission Process for Medi-Cal Eligible or My Health LA Eligible but Not Enrolled

Claims Submission Process for Medi-Cal Eligible or Enrolled and My Health LA (MHLA) Eligible or Enrolled				
Status		Financial Eligibility Form	Authorization Form	Claims Process
Medi-Cal Eligible or Enrolled (i.e., transferring Medi-Cal benefits to Los Angeles County):	When applying for Medi-Cal (i.e., Medi-Cal is pending)	Select 1) " Applying for Medi-Cal " as primary guarantor and 2) " LA County - Non DMC " as secondary guarantor	Authorizations will be granted for no more than 60 days.	Submit claims for services provided up to the 60th day of treatment.
	Once approved for Medi-Cal or benefits are successfully transferred to LA County	1) Update " Applying for Medi-Cal " to " California Department of Alcohol and Drug " for the primary guarantor. 2) Make sure " LA County - Non DMC " is selected as secondary guarantor	Once a patient is approved for Medi-Cal, the provider should submit a new Authorization with a start date of the 61st day of treatment through the end of the regular authorization period for the type of service being requested.	Once Medi-Cal has been approved and the Financial Eligibility Form has been updated, submit claims following the usual process. Note: For days 61+, any unpaid reimbursable services will be retroactively paid by SAPC.
	If a patient has been denied for Medi-Cal, but is eligible for other County funding: AB 109 PSSF JJCPA, or Title IV-E	1) Delete " Applying for Medi-Cal " as the primary guarantor. 2) Update the primary guarantor to " LA County - Non DMC ". Be sure to ensure that all payor sources a patient qualifies for is identified and updated on their CalOMS.	Authorizations will be granted for the full period of time for the type of service being requested within the eligibility period.	Once Medi-Cal has been denied, and the Financial Eligibility Form has been updated, submit claims following the usual process. Note: For days 61+, any unpaid reimbursable services will be retroactively paid by SAPC.
My Health LA Eligible or Enrolled:	When applying for MHLA	Select " LA County - Non DMC " as the primary guarantor.	Be sure to document patient's application to MHLA. Authorizations will be granted for the full period of time for the type of service being requested within the eligibility period.	Submit claims following the usual process.
	Once approved for MHLA			

Note: Effective August 7, 2017, same day billing is allowed for certain SUD services and a multiple billing code form is no longer required for allowable services. For a list of allowable services, see the *DMC ODS Same Day Billing Matrix* on DHCS' [website](#).

Cost Reporting

It is required by law (HSC 11852.5 and WIC 14124.24) that cost reports are to be submitted to the State to determine how State/Federal funds are spent. **Cost reports are due no later than 60 days after the close of the fiscal year (August 30).**

Overview of Cost Report Settlement Process

DHCS releases cost report forms, instructions, and supporting documents to counties. Counties distribute appropriate forms and instructions to their contracted providers (DHCS does not have prescribed data collection forms for non-DMC providers, so counties may use other forms or processes to collect cost report data from those contracted providers). Providers collect and report cost data on the county (Non-DMC) or DHCS-required forms and submit them to the county. The county enters cost report data into the SUDCRS and submits it to DHCS.

County Cost Report Responsibilities

Distribute Forms and Instructions to Contracted Provider

It is the county's responsibility to distribute applicable cost report materials to its contracted providers.

As soon as DHCS releases the annual forms and instructions for the prior fiscal year's cost report, the county must distribute the DMC Cost Report (Excel) Workbook to their contracted DMC providers. DHCS also provides an informational reconciliation report that reflects all approved and denied services by providers. If a provider's name appeared on this report, the provider is required to submit cost report. DHCS typically gives counties three (3) to four (4) months to complete and submit their cost reports, so it is critical that counties give their providers a due date that allows the county sufficient time to review provider data, return to the provider for corrections if needed, and enter the data into the SUDCRS. Any manipulation to the cost report template format and/or formulas will deem the cost report null and void.

Collect and Review Data from contracted Providers

Counties that provide DMC services must collect cost data from their contracted DMC providers via the DHCS-prescribed DMC cost report workbook. DMC providers are responsible for completing the DMC cost report workbook and submitting it to the county. A workbook must be completed for each location that has a unique DMC number. The provider must certify that the cost report information is true, correct, and in compliance with federal law.

DMC Cost Settlement Methodology

The rate at which a provider bills for DMC services is an interim rate until the cost report is settled. SAPC will settle to the lower of cost or charges.

DMC Provider Cost Report Workbook

Cost Allocation Considerations

The provider must have a cost allocation plan that identifies, accumulates, and distributes allowable direct and indirect costs and identifies the allocation method(s) used for distribution of indirect costs. The provider must determine their allocation methodology in accordance with

applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1, 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy.

A. Direct Cost Allocation

- The direct cost allocation methodology adopted by the provider must assign costs to a particular cost objective based on benefit received by that cost objective.
- Any method of distribution can be used that will produce an equitable distribution of cost.
- In selecting one method over another, consideration should be given to the additional effort required to achieve a greater degree of accuracy.

B. Indirect Cost Allocation

- For consistency, efficiency, and compliance with Federal laws and regulations, the DMC workbook allocates indirect costs using a standard methodology. The workbook identifies the direct cost categories for each modality and uses the percentage of total direct costs to allocate indirect costs.
- DHCS recognizes that there are other allocation bases (such as percentage of direct salaries and wages) that result in an equitable distribution of indirect administrative overhead. However, if a provider wishes to use an allocation basis other than the standard methodology established in the cost report, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must seek DHCS's approval and DHCS will make a final determination of the propriety of the methodology used.

Cost Report Records and Supporting Documentation

The provider must maintain a formal set of financial records that includes a general ledger, as well as books of original entry (cash receipts journal/register, cash disbursements journal/register, and a general journal). Entries in the books of original entry must be traceable to source documentation. Evidence of expenditure must be sufficient to substantiate that the expenditure was incurred, and that the expenditure was necessary for the provision of service. This evidence includes paid invoices, cancelled checks, contracts, purchase orders, and receiving reports.

The provider must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained until the later of: (1) a financial audit is conducted; or (2) a period of three (3) years following the date of the interim cost settlement. All records of funds expended, and costs reported are subject to review and audit by DHCS and/or the Federal government pursuant to the Welfare and Institutions Code Section 14124.24(g) (2) and 14170.

Cost Report Training and Preparation

County provides cost report training to all providers every year during the month of August. If you do not receive invitation from us, please contact Lisa Lee at (626) 299-4165, or e-mail lislee@ph.lacounty.gov

To prepare a cost report, the following documents will be needed:

- A. County contract
- B. General ledger for each site

- C. Units billed for the fiscal year
- D. Download cost report forms and instructions from SAPC's website

Forms are available on SAPC's website at www.publichealth.lacounty.gov/sapc.

Cost Report Submission

Submit the complete set of cost report via email and mail with original signature to:

County of Los Angeles
Department of Public Health
Substance Abuse Prevention and Control
Cost Reporting Unit
1000 S. Fremont Avenue., Building A-9 East
3rd Floor, North Wing, Unit # 34
Alhambra, California 91803

Cost Report Delinquent

SAPC may impose sanction for non-receipt of the cost report. Under contract Section 5.G: "If the Annual Cost Report is not delivered by Contractor to County within the specified time, Director may withhold all payments to Contractor under all service contracts between County and Contractor until such report is delivered to County and/or, at the Director's sole discretion, a final determination of amounts due to/from Contractor is determined on the basis of the last monthly billing received. Failure to provide the annual cost report may constitute a material breach of the Contract, at the sole discretion of the County, upon which the County may suspend or terminate this Contract."

Cost Reconciliation Process, Required Report, and Settlement

Preliminary Cost Report Settlement

The Preliminary report is the cost report settlement between County and providers that is submitted to the State for review.

SAPC receives the Units of Service Reconciliation Report from the State and sends it to each provider respectively. Providers then reconcile their billing record with the State's report. Providers submit their cost report to SAPC using the State's DMC Cost Report Form. The method of Lower of Cost (Program cost) or Charges (Total Units * Rate) will be calculated. SAPC then submits the cost report to the State. SAPC will determine the lower of cost or charges and process a settlement invoice and letter to provider. Participant/Patient Fees and 3rd Party Revenue collected will be offset from allowable cost.

Interim Cost Report Settlement

The Interim report is the cost report settlement that has been approved by the State. *Note: The State may have made adjustments to reflect the final approved and denied unit of services for the fiscal year.*

The County receives the Interim Cost Report Settlement from the State 18 months after the preliminary cost report was submitted. This report reflects additional approved/ denied units as well as the State Final Approved Allowable Cost. SAPC uses this report to process the interim cost report settlement with providers using the same method, Lower of Cost (Program Cost) or Charges (State Final Approved Allowable Cost). SAPC then sends the Interim Cost Report Settlement invoice and letter to providers.

Note: The charges used at the Interim Cost Report Settlement is the State Final Approved Allowable Cost.

Information Technology Management

As the specialty SUD system better integrates into mainstream health care, there is a need to transition from a largely paper-based SUD system to an electronic, technology-based system to support integration and enhance service delivery. As such, it is important for SUD provider agencies to incorporate information technology (IT) considerations (e.g., staff, hardware, software, infrastructure) into their business planning to ensure a foundation of technological success, both from a business and clinical perspective.

Sage and Electronic Health Record Requirements

Collecting and sharing knowledge about patients through a centralized platform results in more confident decision-making when planning, delivering, monitoring, and billing for SUD services that are offered. As a result, EHR systems are the backbone of strong organizations and health systems.

Electronic health records (EHRs) are patient records that can be created and managed by authorized providers in a digital format capable of being shared with other providers. This interoperability between EHRs facilitates care coordination and information exchange, and ultimately improved patient care. Additionally, EHR systems often contain information beyond patient records, including assessment tools, processes to support utilization management, data reporting, and billing, among other functionalities.

As the SUD system becomes a specialty health system operating in a managed care environment, providers need EHR systems to document, organize, bill, and communicate their service delivery with other providers within the SUD continuum of care, as well as with providers outside of the specialty SUD system.

As a result, SUD provider sites are required to possess a certified EHR to ensure the delivery of high quality specialty SUD services in a managed care environment.

Sage

Sage is a certified, web-based SUD EHR that consists of clinical, administrative, and data reporting modules that satisfy mandatory government reporting and interoperability requirements and provides the necessary framework for overseeing and delivering SUD services in a managed care environment. It is 42 CFR Part 2 and HIPAA compliant. **Figure 6** outlines the various functionalities of Sage, which includes all the capability a specialty SUD provider would need to operate within the SAPC network.

To help facilitate the transition from a paper-based specialty SUD system to an electronic system, SAPC is funding the development, implementation, ongoing maintenance and support, and initial trainings for Sage. Ongoing trainings will be the responsibility of SUD provider agencies.

Additional information on Sage is available on the SAPC website at <http://publichealth.lacounty.gov/sapc/Sage/Sageinfo.htm>, including details on trainings, User Access Groups, billing, and ASAM CONTINUUM assessment trainings.

Providers Eligible for Sage

The EHR system that specialty SUD providers use is an individualized business decision. While Sage is NOT required for all SAPC providers, all SAPC providers are required to possess a certified EHR that is approved by SAPC.

Sage is available to both SUD providers that do not currently have an EHR or that have an EHR already but choose to switch systems. Providers who elect to continue using their SAPC-approved EHR system may continue to do so, so long as they work with SAPC IT to ensure necessary data exchange.

For providers who elect to utilize Sage, it will be used for all treatment service providers within the specialty SUD system. In OTP settings, a portal for Sage will be used to access ASAM assessments, the Utilization Management module, billing, and data reporting. Otherwise, the clinical functions of OTPs will remain on their current EHR systems.

Prevention and DUI services will not be utilizing Sage at this time.

Sage Access Group Management

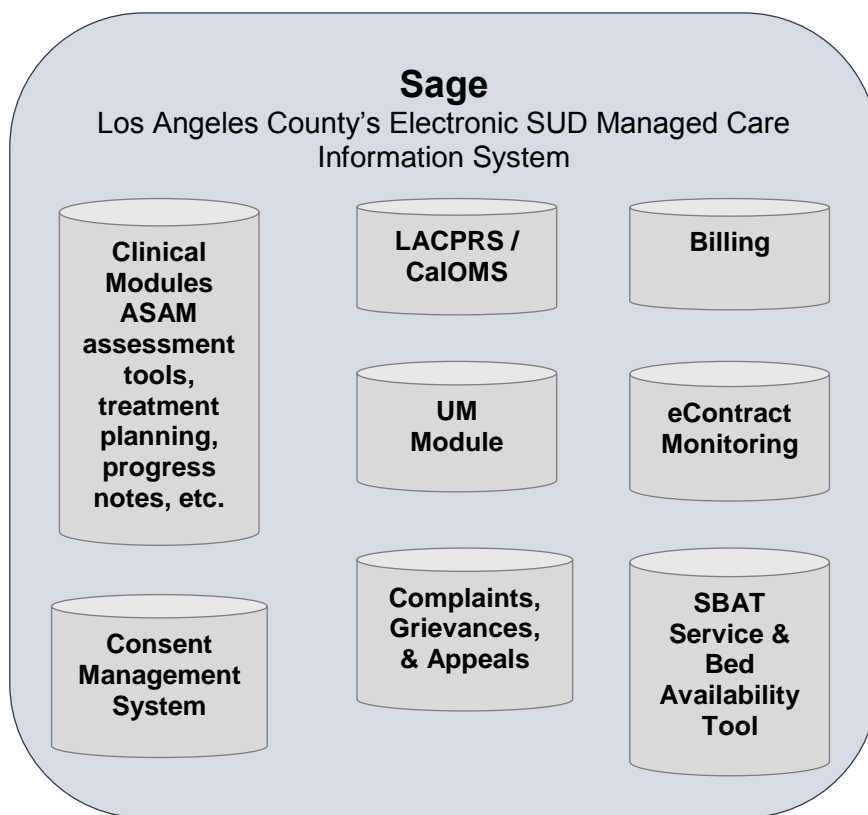
To fully utilize all the benefits that Sage has to offer, SUD providers should manage the access groups that they grant their staff. Sage is designed to capture most SUD provider staff roles to allow for most provider functions, these include:

- Varying Clinical Levels in LPHA, Counselors, and Licensed-Eligible LPHA, and those who also conduct financial tasks
- Financial Staff
- Student/Intern
- Audit User
- Operations
- Clerical

SUD Providers should visit the following link for more information on Sage, including managing access groups for staff: <http://publichealth.lacounty.gov/sapc/Sage/SageInfo.htm>

Note: SAPC will review all access groups to ensure that roles are appropriately assigned.

Figure 6. Sage: Los Angeles County's Electronic Information System



Provider Responsibilities

With regard to their EHR systems, SUD providers are expected to:

- Recognize the critical importance of EHR systems to the delivery of high quality SUD care.
- Include IT planning into their business plans to ensure sufficient hardware specifications, up-to-date anti-virus protection, latest windows security patches, and IT staff to support their EHR.
- Ensure staff are appropriately trained on their EHR to use it proficiently.
- Notify SAPC of issues so collaborative solutions can be identified.
- Develop procedures to ensure treatment and other services are not interrupted by planned or unplanned outage events.
 - To prepare for such events, SUD treatment providers must maintain the following documents in hard copies or other formats not impacted by Sage: current patient roster, ASAM Assessment tool, Service Request Form template, Treatment Plan template, Progress Note template, Miscellaneous Note template, Discharge and Transform template (for all LOCs), RBH Authorization Request form and Discharge form, billing required documents, all required consent, Admission/Discharge forms, and any other documents required by the County.

Sage Trainings

For provider agencies that elect to utilize Sage, while SAPC will support the start-up training for Sage, SUD providers are responsible for ensuring their staff receive sufficient training on Sage to ensure proficiency and for planning ahead to accommodate staff turnover by developing and

leveraging internal super-user expertise. To facilitate Sage trainings, SAPC has worked with the vendor and will require providers opting to utilize Sage to purchase SAPC-approved trainings through Netsmart to ensure quality. These trainings will be online, instructor-assisted training courses, and are allowable costs for provider budgets. Prior to being given access to Sage, users will be required to demonstrate proficiency by successfully passing a written competency exam.



SECTION 5.

APPENDICES

Definitions

Glossary of Terms	
ASAM Triage Tool	This is a short screener based on ASAM criteria used to determine if adults and young adults need SUD treatment and the provisional level of care they would most likely benefit from.
Assessment	<p>The process for defining the nature of an issue, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis. Assessment are ASAM based which examines six dimensions:</p> <ol style="list-style-type: none"> 1. Acute intoxication and/or withdrawal potential 2. Biomedical conditions and complications 3. Emotional, behavioral, or cognitive conditions and complications 4. Readiness to change 5. Relapse, continued use, or continued problem potential 6. Recovery/living environment <p>At a minimum, comprehensive assessments include the following elements:</p> <ul style="list-style-type: none"> • History of the present episode • Substance use and addictive behavior history • Developmental history (as appropriate) • Family history • Medical history • Psychiatric history • Social history • Spiritual history • Physical and mental status examinations, as needed • Comprehensive assessment of the diagnose(s) and pertinent details of the case • Survey of assets, vulnerabilities, and supports • Treatment recommendations • Financial status/history • Educational history • Employment history • Criminal history/Legal status
Beneficiary	Recipient of Medi-Cal
Care Coordination	Bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care.
Case Management	A service to assist patients in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. It is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-

Glossary of Terms

	effective outcomes. In order to link patients with services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate services needed for the patient to optimize care through effective, relevant networks of support.
Chronic Homelessness	Having a disability and living in a place not meant for human habitation, in an emergency shelter, or a safe haven for the last 12 months continuously or on at least four occasions in the last three years where those occasions cumulatively total at least 12 months (United States Department of Housing and Urban Development 2016).
Cognitive Behavioral Therapy	A short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Cognitive behavioral therapy (CBT) focuses on exploring relationships between a person's thoughts, feelings and behaviors. During CBT, a therapist will actively work with the patient to uncover unhealthy patterns of thought and how they may be causing self-destructive behaviors and beliefs. By addressing these patterns, the patient and therapist can work together to develop constructive ways of thinking that will produce healthier behaviors and beliefs.
Collateral Services	Whenever possible and as it is relevant to treatment goals, the certified SUD counselor or LPHA shall engage significant individuals in the patient's personal life (i.e. family member, partner). The focus may include psychoeducation or diminishing barriers to treatment goals. Sessions may occur face-to-face, via telephone, or telehealth.
Co-Occurring Disorder	A concurrent substance use and mental disorder.
Crisis Intervention Services	Contact between a certified SUD counselor or LPHA and a patient in crisis. The service priority should be to alleviate crisis problems and may need to involve a team approach. "Crisis" is defined as a threat to physical and/or mental health and well-being of the patient or a known party. Depending on the circumstance, it may also mean a serious relapse or an unforeseen event or circumstance that presents as an imminent threat of serious relapse. Crisis intervention services shall be limited to the stabilization of the patient's emergency situation and should include linkages to appropriate services to ensure ongoing care following the crisis situation.
Culturally Competent Services	Providers are required to ensure that treatment services are delivered in such a way that interactions with people representing culturally, linguistically, and developmentally diverse groups are effective, address their individualized needs and optimize treatment engagement. Organizational policies, procedures, and practices must be consistent with the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care and embedded into the organizational day-to-day operations.

Glossary of Terms

Discharge Plan	The document that details of the patient's planned discharge. The Discharge Plan shall include, but not be limited to, the following: <ul style="list-style-type: none"> • A description of each of the beneficiary's relapse triggers • A plan to assist the beneficiary to avoid relapse • A support plan
Discharge Services	The process of preparing the patient for referral into another level of care, post-treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. The discharge service process should be initiated from the onset of treatment services. This serves to ensure sufficient time to plan for the patient's transition to subsequent treatment or recovery support services and, from a clinical standpoint, to convey that recovery is an ongoing life process not a unit of service.
Discharge Summary	The report filled out when the patient leaves treatment and the provider is unable to contact them.
Documentation	DPH-SAPC will require that providers generate initial documentation based on the ASAM Criteria. The documentation must provide justification for the care provided, including the demonstration of medical necessity. Documentation templates developed by DPH-SAPC shall be used for Treatment Plans, progress notes, and other documentation developed by the Quality Improvement/Utilization Management (QI/UM) Unit. Services provided in the community, by telephone, or by telehealth require equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility.
Drug Testing	While there is currently no widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. The frequency of drug testing should be based on the patient's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued drug use has been identified to be more common. Additionally, drug testing is best when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) would ideally vary as well.
Early and Periodic Screening, Diagnostic and Treatment	A benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. It is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.
Evidence-based Practice(s)	Practices that have been implemented and are supported by evidence. Providers will be expected to implement, at a minimum, the two EBPs of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). Other EBPs include relapse prevention, trauma informed treatment, family therapy and psychoeducation.
Face-to-Face	Occurring in person at a certified facility. Telephone contacts, telehealth, home visits, and hospital visits are not considered face-to face.

Glossary of Terms	
Family Services	Sessions involving patients and their family members in multi-family group sessions. These services can be provided by a certified SUD counselor or and LPHA. Sessions can be education or counseling focused.
Family Therapy	Psychotherapy, involving both the patient and their family members, that uses specific techniques and evidence-based practices (e.g., family systems theory, structural therapy, etc.). The effects of addiction are far-reaching and patients' family members and loved ones also are affected by the disorder. By including family members in the treatment process, clinicians provide education about factors that are important to the patient's recovery as well as their own recovery. Family members can provide social support to the patient, help motivate the patient's loved ones to provide social support to the patient, help motivate the patient to remain in treatment, and receive help and support for their own family recovery as well. These services must be provided by an LPHA-level therapist (see below for qualifying professions).
Field-based Services	Services that are provided at a location other than a brick and mortar treatment agency. Services may be provided to adults and youth, as well as parents or guardians, as needed. Service locations include, but are not limited to, patient's residence, recreational centers, sober living facilities, homeless encampments, and co-locations in emergency departments, primary care, mental health, court, jail re-entry (not in-custody), probation, and child protective services settings. Field-Based Services for MAT should be provided by staff that are specifically trained to recognize and respond to the unique biopsychosocial needs of their patients. Field-Based Services are responsive and appropriate to the cultural, linguistic, and developmental needs of patients, and are supported by evidence-based practices.
Group Counseling	Face-to-face contact between one or more certified or registered SUD counselors or LPHA, and two or more patients at the same time (with a maximum of 12 patients in the group). Psychosocial issues related to substance use are addressed utilizing relevant best practice clinical interventions and a focus on peer support. Note: Group sign-in sheets must include signatures and printed names of all participants (including participants not reimbursed by SAPC and family members) and group facilitators, date, start/end times, location, and group topic.
Homelessness as defined by HUD	HUD definition of homelessness includes four categories: 1) Literally Homeless : individual or family who lives in a place not meant for human habitation or in an emergency shelter or is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

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	<p>2) Imminent Risk of Homelessness: Individual or family who will imminently lose their primary nighttime residence within 14 days and who lacks the resources to obtain other permanent housing;</p> <p>3) Homeless Under Other Statutes: includes unaccompanied youth under 25 or families with children and youth who have experienced persistent instability (see terms and definitions for more information); and</p> <p>4) Fleeing/Attempting to Flee Domestic Violence: An individual or family attempting to flee DV who has no other residence and lacks the resources or support networks to obtain other permanent housing.</p>
High Utilizer	<p>A high utilizer is a person who is diagnosed with a SUD who meets any of the following criteria:</p> <ul style="list-style-type: none"> • 3+ ED visits related to SUD within the past 12 months • 3+ inpatient admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD • Homelessness with SUD (as defined by HUD homelessness definition) • 3+ residential SUD treatment admissions within the past 12 months • 5 + incarcerations with SUD in 12 months
Imminent Danger	<p>Imminent danger has the following three components:</p> <ol style="list-style-type: none"> 1. A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or non-compliance with psychiatric medications) 2. The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated) 3. The likelihood that such adverse events will occur in the very near future <p>In order to constitute “imminent danger” ALL THREE ELEMENTS must be present.</p>
Individual Counseling	<p>Clinical contact between a LPHA or counselor and a patient that addresses psychosocial issues related to substance use disorders. DPH-SAPC’s required evidence-based techniques include Motivational Interviewing and Cognitive Behavioral Therapy. Services may be provided in-person, by telephone, or by telehealth.</p>
Intake	<p>The process of determining that a patient meets the medical necessity criteria for care, and then admitting a patient into a SUD treatment program. Intake includes the assessment or analysis to determine whether or not an individual meets the current DSM-5 criteria for an SUD diagnosis or is at-risk for SUD. It also involves using the ASAM Criteria to determine if treatment is medically necessary as well as identifying the appropriate level of care. Intake for a pharmacological intervention</p>

Glossary of Terms	
	includes a physical examination and laboratory testing necessary for determining and providing appropriate SUD treatment.
Lapse	A brief return to substance use following a sustained period of abstinence, despite the patient remaining committed to recover and demonstrating a willingness to re-engage with the recovery journey.
Licensed Practitioner of the Healing Arts (LPHA)	<p>A LPHA possesses a valid clinical licensure or certification in one of the following professional categories:</p> <ul style="list-style-type: none"> • Physician (MD or DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Registered Nurse (RN) • Registered Pharmacist (RP) • Licensed Clinical Psychologist (LCP) • Licensed Clinical Social Worker (LCSW) • Licensed Professional Clinical Counselor (LPCC) • Licensed Marriage and Family Therapist (LMFT) • Licensed-Eligible LPHAs working under the supervision of licensed clinicians
Medical Necessity	<p>Medical necessity for all substance use disorder treatment provided under a DPH-SAPC contract is defined as:</p> <p>(Adults)</p> <ul style="list-style-type: none"> • At least one diagnosis of a substance-related and addictive disorder, with the exception of tobacco-related disorders, from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). • Appropriate placement in a substance use disorder level of care that is consistent with recommended services and medical necessity based on the current edition of the American Society of Addiction Medicine (ASAM) Criteria. <p>(Youth)</p> <ul style="list-style-type: none"> • At least one diagnosis of a substance-related and addictive disorder, with the exception of tobacco-related disorders, from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5); <p>OR</p> <ul style="list-style-type: none"> • Assessed to be at-risk for developing a substance use disorder (for youth under age 21). • Any qualified provider operating within the scope of their practice, as defined by state law, can provide a screening service to trigger EPSDT coverage and medically necessary SUD treatment for youth up to age 21.

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	Appropriate placement in a substance use disorder level of care that is consistent with recommended services and medical necessity based on the current edition of the American Society of Addiction Medicine (ASAM) Criteria.
Medical Psychotherapy	Medically-oriented psychotherapy consists of a one-on-one face-to-face session with the patient and either the Medical Director, or their designated OTP licensed prescriber(s). The goal is to explain medication treatment, which can be complex, and enable the patient to provide informed consent. The meeting focuses on medication options (risks and benefits of proposed intervention, alternatives, risks and benefits of foregoing any intervention, potential side effects, etc.), and other components of person-focused care that are necessary in order to provide a comprehensive range of medical and rehabilitative services. See Section 10345 of Title 9, CCR
Medication Services	Medication Services including MAT, will be discussed and offered as a concurrent treatment option for individuals with an alcohol- and/or opioid-related SUD condition. The prescription or administration of MAT, and the assessment of side effects and/or impact of these medications, should be conducted by staff lawfully authorized to provide such services within their scope of practice and licensure. Youth under age 18 are eligible for MAT on a case-by-case basis with parental consent and DPH-SAPC authorization.
Methadone	An opiate agonist medication that has been approved for use in narcotic replacement therapy.
Motivational Interviewing	Motivational Interviewing focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. The method differs from more “coercive” or externally-driven methods for motivating change as it does not impose change (that may be inconsistent with the person's own values, beliefs or wishes); but rather supports change in a manner congruent with the person's own values and concerns.
Patient Education	The presentation of research-based education on addiction, treatment, recovery and associated health risks with the goal of minimizing the use of addictive substances, lowering the risk of dependence, and minimizing adverse consequences of substance use. Group counseling size parameters apply (maximum of 12 patients per group) if patient education is conducted in a group setting.
Peer Support	Peers give and receive nonprofessional, nonclinical assistance to achieve long-term recovery for beneficiaries. The support is provided by individuals who have experiential knowledge. Peers provide assistance to promote a sense of belonging within the community. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery

Glossary of Terms

	of experiences and finding meaning, purpose, and social connections in their lives.
Physical Examination	Appropriate medical evaluation must be performed prior to initiating treatment services, including physical examinations when deemed necessary.
Provisional Level of Care	The initial level of care that is determined by the ASAM triage tool. It will be replaced with the actual level of care once the patient has received a full ASAM Continuum or SAPC Youth ASAM assessment at the treatment agency. The purpose of the provisional level of care is to increase the likelihood that the patient is directed to the appropriate treatment agency for them the first time.
Recovery Bridge Housing	Recovery Bridge Housing (RBH) is defined by DPH-SAPC as a type of abstinence-focused, peer-supported housing that combines a payment for recovery residences with concurrent treatment in outpatient, intensive outpatient, Opioid Treatment Program, or outpatient withdrawal management settings. RBH is often appropriate for individuals with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions. If there is risk potential, these concerns are to be managed by the treating provider.
Recovery Support Services (RSS)	Recovery support services will address all needs identified in Dimension 6 of the ASAM Criteria (See Recovery Environment of the ASAM Criteria below) and services will be provided face-to-face, by phone or via a telehealth modality. RSS will include monitoring all six ASAM dimensions. Relapse education and warning sign monitoring will occur throughout the duration of Recovery Services. Adults and youth will both be linked to services that will address their psychosocial issues, help them develop self-management skills, and reinforce skills gained during treatment.
Relapse	A prolonged episode of substance use during which the patient is not interested or open to a therapeutic intervention.
Transportation Services	Providing transportation or making arrangement for transportation to and from medically necessary treatment
Treatment Planning	<p>The provider (certified SUD counselor or LPHA) shall prepare an individualized written Treatment Plan, based upon information obtained in the intake and assessment process. The Treatment Plan will be completed upon intake. The review and updating of Treatment Plans will depend on the level of care in which treatment is delivered. The Treatment Plan shall include:</p> <ol style="list-style-type: none"> 1. A statement of problems to be addressed. 2. Goals to be reached which address each problem. 3. Action steps to be taken by the provider and/or patient to accomplish identified goals; 4. Target dates for accomplishment of action steps and goals. 5. A description of services including the type of counseling to be provided and the frequency thereof.

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	<ol style="list-style-type: none"> 6. Specific quantifiable goals and treatment objectives (e.g., SMART goals that are <u>S</u>pecific, <u>M</u>easurable, <u>A</u>ttainable, <u>R</u>ealistic, and <u>T</u>ime-bound) related the patient's SUD diagnosis and multidimensional assessment. 7. The proposed type(s) of interventions/modalities that includes frequency and duration of intervention(s). 8. A diagnosis including DSM codes 9. The assignment of a primary therapist or counselor 10. Physical exam goal or documentation <p>A Treatment Plan that is consistent with the qualifying diagnosis and must be signed by the patient and the LPHA or Medical Director.</p>
Warm Handoff	<p>When a treatment agency, case manager, counselor, etc. refers a patient for additional services related to their treatment. This is not a simple referral but entails going the extra step to ensure that the patient feels supported and is not left to their own devices. An example is when a counselor calls another counselor, introduces the patient to the counselor, and then sets up a meeting between the patient and new counselor. The patient will go into the meeting having already been introduced to the new counselor.</p>
Your Benefits Now System	<p>This Department of Public Social Services website is used to verify Medi-Cal enrollment and is available to all providers for use. Providers must establish an account in order to use it.</p>

Acronyms

Acronym Glossary	
AB	Assembly Bill
ASAM	American Society of Addiction Medicine
ATT	ASAM Triage Tool
ATC	Alternatives to Custody
BOT-LA	Back on Track – Los Angeles
CalWORKs	California Work Opportunity and Responsibility to Kids
CAP	Corrective Action Plan
CBO	Community-Based Organization
CBT	Cognitive Behavioral Therapy
CCR	California Code of Regulations
COD	Co-Occurring Disorders
CODC	Co-Occurring Drug Court
CENS	Client Engagement and Navigation Services
CES	Coordinated Entry System
CFR	Code of Federal Regulations
CFT	Child Family Team
CIBHS	California Institute for Behavioral Health Solutions
CIN	Client Identification Number
CLAS	Culturally and Linguistically Appropriate Services
CPA	Contract Program Auditor
CPT	Central Processing Team
CQI	Continuous Quality Improvement
CRDF	Century Regional and Detention Facility
CRRC	Community Re-entry and Resources Center
CSR	Clinical Services and Research
CSW	Children's Social Worker
DCFS	Los Angeles County Department of Children and Family Services
DCMIS	Drug Court Management Information System
DMC	Drug Medi-Cal
DMH	Los Angeles County Department of Mental Health
DPSS	Los Angeles County Department of Public Social Services
DO	Doctor of Osteopathic Medicine
DOJ	California Department of Justice
DPH	Los Angeles County Department of Public Health
DPO	Deputy Probation Officer
DSM	Diagnostic and Statistical Manual
EBP	Evidence-based Practices
EHR	Electronic health record
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FBS	Field-based services
FDA	Food and Drug Administration
FDDC	Family Dependency Drug Court

Acronym Glossary	
FFS	Fee-for-service
GAIN	Greater Avenues for Independence
GPS	Global Positioning Satellite
GR	General Relief
GSW	GAIN Services Worker
HCPCS	Healthcare Common Procedure Coding Systems
HIPAA	Health Insurance Portability and Accountability Act
HUD	U.S. Department of Housing and Urban Development
IOP	Intensive Outpatient
JDDC	Juvenile Delinquency Drug Court
JJCPA	Juvenile Justice Crime Prevention Act
LACPRS	Los Angeles County Participant Reporting System
LASD	Los Angeles County Sheriff's Department
LGBTQ	Lesbian, Gay, Bi-sexual, Transgender, Questioning
LPHA	Licensed Practitioner of the Healing Arts
LRS	LEADER Replacement System
MAT	Medication Assisted Treatment
MD	Doctor of Medicine
MDT	Multi-Disciplinary Team
MDTT	Misdemeanor Diversion Treatment Track Project
MEDS	Medi-Cal Eligibility Data System
MI	Motivational Interviewing
N3	Non-violent, Non-serious, and Non-sexual
N3 Split	Non-violent, Non-serious, and Non-sexual (N3) with a condition of probation supervision upon release
NARR	National Alliance for Recovery Residences
NP	Nurse Practitioner
OMDSO	Office of the Medical Director and Science Officer
OP	Outpatient
OTP	Opioid Treatment Program
PA	Physician Assistant
PAUR	Prospective Authorization and Utilization Review Unit
PC	Penal Code
PES	Psychiatric Emergency Services
PIP	Performance Improvement Project
PPG	Perinatal Practice Guidelines
PSP	Post-release Supervised Person
PSPC	Policy/Strategic Planning/Communications
PSSF-TLFR	Promoting Safe and Stable Families Time Limited Family Reunification
QI	Quality Improvement
QIP	Quality Improvement Project
RBH	Recovery Bridge Housing

Acronym Glossary	
RNR	Risk, Needs, Responsivity
RSS	Recovery Support Services
SAMHSA	Substance Abuse and Mental Health Services Agency
SAPC	Substance Abuse Prevention and Control
SASH	Substance Abuse Services Helpline
SBAT	Service and Bed Availability Tool
SMART	Specific, Measurable, Attainable, Realistic, and Time-bound
SPA	Service Planning Area
START-ODS	System Transformation to Advance Recovery and Treatment, Los Angeles County's Substance Use Disorder Organized Delivery System
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TAY	Transition Age Youth
TBI	Traumatic Brain Injury
TCPX	Treatment, Court, Probation, eXchange System
UCC	Urgent Care Center
UCLA-ISAP	University of California Los Angeles – Integrated Substance Abuse Programs
UM	Utilization Management
VA	Veteran's Administration
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
WM	Withdrawal Management
WtW	Welfare-to-Work
YBN	Your Benefits Now
YES	Youth Engagement Screener

Case Management References

Case Management Scenarios		
<p>Note: Although not an exhaustive list, these scenarios are meant to help providers distinguish between the types of services that are and are NOT billable under Case Management. The non-billable scenarios listed include activities that should be conducted, when appropriate, but cannot be billed under Case Management.</p>		
	Billable	Non-Billable
Connection	<ul style="list-style-type: none"> Actively helping patients apply for Medi-Cal Completing the Coordinated Entry System Survey Packet including the Vulnerability Index - Service Prioritization Decision Assistance Tool for adults, or the Next Step Tool for youth; and linking patients to housing resources. Transferring Medi-Cal benefits for patients who have moved, from the previous county of residence to Los Angeles County. Linking patients to community resources such as food and clothing assistance. 	<ul style="list-style-type: none"> Providing transportation for patients to scheduled appointments. Providers should arrange transportation for patients to and from appointments and attend scheduled appointments, if patient consent is given. However, the time spent traveling to and from appointments is non-billable (except for patients in Residential Treatment, which is covered in the day rate and Perinatal patients in the Perinatal Practice Guidelines).
Coordination	<ul style="list-style-type: none"> Identifying a referral agency by using the Service and Bed Availability Tool (SBAT) and scheduling an appointment for a level of care transition (e.g., from Intensive Outpatient or ASAM 2.1 to Low Intensity Residential or ASAM 3.1, etc.). Coordinating action plans with mental health providers to ensure patients are provided complementary services. 	<ul style="list-style-type: none"> Documenting case management activities in Miscellaneous Notes, including information regarding recent primary care and specialist visits, emergency room visits, auxiliary treatment services (e.g., dialysis), and any community resources received. Although providers are expected to conduct these activities, time spent documenting these activities are non-billable.
Communication	<ul style="list-style-type: none"> Entering and updating data into the Treatment Court Probation eXChange (TCPX), Drug Court Management Information System (DCMIS), and Clarity Homeless Management Information System (HMIS). Data entry into Probation Department's web-based reporting system for JJCPA referrals Time spent communicating with service providers, county workers, judges, etc., either face-to-face or by phone (e.g., meeting with patient and doctor during a primary care visit). Following up with other agencies regarding scheduled services and/or services received by patients. Providing written or verbal status reports to health and mental health providers, and county partners (e.g., Department of Children and Family Services, Probation Department). 	<ul style="list-style-type: none"> Entering data into Sage (pre-authorizations, authorizations, progress notes, etc.). Attempting, but not successfully contacting service providers either by phone or face-to-face. Providers should only bill for Case Management if they are successful in communicating with other service providers on the patients' behalf.

Case Management Checklist

Note: This checklist is a reference tool for use during Case Management sessions to ensure that core functions of case management, and their respective activities, are being performed. This is not meant to be an exhaustive list of case management activities. This table is intended to offer examples of activities that should be covered in sessions, when applicable, and can be billed as Case Management.

Topics		Potential Activities	Performed in session? (Y/N)
Connection	Establishing & Maintaining Benefit	Actively help patients to apply for and maintain health and public benefits (e.g., Medi-Cal, My Health LA, General Relief, Perinatal, Housing, etc.).	
		Transfer Medi-Cal benefits from the previous county of residence to Los Angeles County for patients who have moved.	
	Community Resources	Link patients to community resources and services (e.g., transportation, food and clothing assistance, family planning services, legal assistance, educational services, vocational services, housing, etc.)	
Coordination	Transitions in SUD LOC's	Facilitate necessary transitions in substance use disorder levels of care (e.g., initiating referrals to the next level of care, coordinating with and forwarding necessary documentation to the accepting treatment agency, etc.).	
	Health Services	Coordinate care with physical health, community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery.	
	Social Services	Coordinate activities with state, County and community (e.g., DPSS, DCFS, Probation, Superior Courts, Housing Providers, etc.) entities.	
Communication	Other Health Providers	Communicate face-to-face or by phone with physical health, community health clinics and providers, and mental health providers	
	Service Partners	Communicate face-to-face or by phone with Department of Public Social Services (DPSS) workers, Department of Children and Family Services (DCFS) social workers, Department of Mental Health (DMH) workers, Probation Officers, Housing Providers, etc.	
	Advocacy	Advocate for patients with health/social service providers, County and community partners, and others in the best interests of patients.	

CENS: Procedure for Additional Co-Location Sites

All negotiations with any entity regarding the possible co-location of CENS staff will be at the direction of DPH – SAPC. CENS are to refer all interested parties to DPH – SAPC if contacted about the possibility of co-locating at a new site, continuing to co-locate at a site, or returning to a site that has been vacated.

CENS providers interested in co-locating at a state, County, city or community facility must follow the steps below:

1. Complete, sign and send the *Request for CENS Co-Location Site* form to SAPC, along with a brief narrative justifying the request to co-locate. The narrative should include the following information:
 - Name and address of agency/organization requesting a CENS to be co-located at their site (e.g., Probation, Court, etc.).
 - The justification for the co-location (e.g., incarcerated clients unable to go to the CENS Area Office for a screening).
 - Number and level of staff needed and hours of operation (i.e., the number of full time equivalents (FTE) and days and hours at the co-located site).
 - Expected number of clients to be seen at the site (e.g., per day, per week, per month, etc.).
2. Unless otherwise directed by DPH-SAPC, execute a Memorandum of Understanding (MOU) or Letter of Agreement with the proposed entity that includes the following information:
 - The host organization contact information, including name, title, phone number and email address.
 - Agreed upon days and times that CENS will be co-located.
 - Detailed description of the roles and responsibilities of the involved entities.
 - Steps taken to assure adherence to confidentiality rules and regulations, including 42 CFR Part 2, Confidentiality of Alcohol and Drug Patient Records, and the Health Insurance Portability and Accountability Act.
3. SAPC reserves the right to approve or deny submitted Requests for CENS Co-Location form at its sole discretion based on the information provided in the narrative and the MOU. SAPC will disallow any services that CENS provides at sites not approved by SAPC.
4. Upon approval of the *Request for CENS Co-Location Site* form and a facility site walk-through by DPH-SAPC, the CENS will be notified of the date when services can begin. CENS co-locations will be reviewed as part of the agency's annual DPH-SAPC program audit.
5. Should DPH – SAPC or CENS determine that a site is no longer viable, notification must be submitted to the other party at least thirty (30) calendar days in advance of the proposed vacancy date.